

EXPERIENCES AND PERCEPTIONS OF IRAQI MUSLIM
REFUGEE WOMEN AND HEALTH CARE PROVIDERS
IN THE HEALTH CARE ENCOUNTER

by

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ABSTRACT

Research indicates that health disparities persist for minorities in the U.S. Sources of health disparities may stem from differences (linguistic, cultural, religious, gender, education) between health provider and patient. This qualitative study explored perceptions and experiences between Iraqi Muslim women with refugee backgrounds and primary health care providers in the context of the health encounter.

Study design was based on critical ethnography and postcolonial feminism that guided semistructured interviews. Participants were purposefully selected from 4 urban clinics and included 15 Iraqi Muslim women patients with refugee backgrounds and 10 primary health care providers. All 10 provider and 5 patient interviews were conducted in English; 10 Iraqi patient interviews were conducted in Arabic, transcribed in Arabic, and translated into English for analysis. Arabic transcriptions and recordings were verified and the English translations were translated back to Arabic. Supportive methods included field notes, and discussions with key informants. The data were coded and categories were formed from repetition of main ideas. Through analysis and interpretation of the data, themes emerged from the categories for each participant group.

Results describe how Iraqi Muslim women face many barriers in seeking health care that are both health system and health provider based. Likewise, health providers are limited in their ability to bridge differences and encounter knowledge deficits about patients as individuals. Both participant groups had expectations of the health encounter

constructed on culturally-based perceptions and expectations. The health encounter is limited by time and inadequate interpretive services that narrow opportunities for clear communication and understanding between provider and patient. These factors combined with individual perceptions and expectations open an avenue for misinterpretation, misdiagnosis, and stereotyping.

Recommendations are given for improving health services to refugees. These include comprehensive changes to the usual confines of the health encounter and avenues for increasing awareness and education of state agencies, health administration, and health providers about the barriers faced by Iraqi Muslim women. In light of the continued health disparities for minority groups, future research is recommended in order to identify the interpersonal elements that contribute to health disparities for patients who are newly arrived to the U.S.

This manuscript is dedicated to the oppressed.

“If you do away with the yoke of oppression,

With the pointing finger and malicious talk,

And if you spend yourselves on behalf of the hungry

And satisfy the needs of the oppressed,

Then your light will rise in the darkness,

And your night will become as the noonday.”

Isaiah 58:9,10

TABLE OF CONTENTS

| | |
|---|------|
| ABSTRACT..... | iii |
| ACKNOWLEDGEMENTS..... | viii |
| CHAPTERS | |
| I INTRODUCTION | 1 |
| Statement of Purpose and Aims | 7 |
| II REVIEW OF THE LITERATURE..... | 18 |
| Introduction..... | 18 |
| Political and Historical Background of Iraq | 19 |
| The Struggle to Obtain Refugee Status..... | 24 |
| Iraqi Refugees in the United States..... | 26 |
| Conceptualizing the Iraqi Refugee in America..... | 29 |
| Representation of Arab Muslims in America | 31 |
| The American Context of Religion and Spirituality | 34 |
| Current Experiences of Arab Americans in the United States..... | 36 |
| The Health of Iraqi Muslim Women with Refugee Backgrounds | 38 |
| Islam and Health | 45 |
| Arab American Health Care Encounters..... | 49 |
| The Health Care Encounter..... | 53 |
| Significance of the Study | 61 |
| III RESEARCH METHODOLOGY AND THEORETICAL FRAMEWORK | 62 |
| Introduction..... | 62 |
| Social Constructionism | 63 |
| Postcolonialism | 64 |
| Postcolonial Feminism..... | 66 |
| Critical Ethnography | 72 |
| Locating Myself | 75 |
| Description of Data Collection | 77 |
| Data Sources | 85 |

| | |
|---|-----|
| Potential Risks | 89 |
| Data Analysis | 91 |
| Strategies for Rigor | 95 |
| Limitations | 98 |
| IV IRAQI MUSLIM WOMEN FINDINGS | 100 |
| Themes | 103 |
| Discussion of Iraqi Participant Data | 134 |
| V HEALTH PROVIDER FINDINGS | 148 |
| Themes | 149 |
| Discussion of Health Provider Participant Data | 197 |
| VI CONCLUSIONS AND RECOMMENDATIONS | 213 |
| The Health Care Environment | 213 |
| Provider and Patient Interaction..... | 220 |
| Clinical Recommendations | 239 |
| Recommendations for Further Research..... | 246 |
| Conclusion | 247 |
| APPENDICES | |
| A. RECRUITMENT FLYER FOR IRAQI PARTICIPANTS..... | 248 |
| B. RECRUITMENT LETTER TO HEALTH PROVIDERS | 250 |
| C. COVER LETTER FOR IRAQI PARTICIPANTS | 252 |
| D. CONSENT COVER LETTER FOR HEALTH PROVIDER PARTICIPANTS | 254 |
| E. IRAQI PARTICIPANT INTERVIEW QUESTIONS..... | 257 |
| F. HEALTH PROVIDER PARTICIPANT INTERVIEW QUESTIONS | 260 |
| REFERENCES | 263 |

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CHAPTER I

INTRODUCTION

Social inequalities in health care are increasingly recognized globally as an important research agenda because of the impact inequalities have on health and because of the growing diversity of nations (Brondolo, Gallo, & Myers, 2009). Inequalities in health persist in the United States for minority patients and are often labeled as health disparities. Minorities in the United States who are most often categorized by race and ethnicity (i.e., Black, Hispanic, Asian, and Pacific Islander) suffer from poor outcomes when measuring health indices and receive poorer quality of care (Smedley, Stith, & Nelson, 2002).

Efforts to address health disparities have been evident in the National Institutes of Health establishment of the National Center on Minority Health and Health Disparities, goals set by Healthy People 2010, and reports from the National Center for Health Statistics (Adler & Rehkopf, 2008). These efforts have led to an extensive research agenda to discern the sources of health disparities. One area of investigation has focused on how the provider and patient interactions may contribute to health inequities (Adler & Rehkopf, 2008; Smedley et al., 2002). Several reasons for health disparities have been suggested within the health care encounter. One area of research has focused on differences between the health provider and the patient. Racial and ethnic differences

have been a major emphasis of inquiries, but results have not consistently found this difference as a source of unequal treatment or health disparity (Chen, Rathore, Radford, Wang, & Krumholz, 2001; Schouten & Meeuwesen, 2006). Some studies have included the patient-provider difference of gender and race as sources of disparities but found that the influence of these differences did not provide clear evidence of unequal care (Rathore et al., 2001; Safdar et al., 2009). Mixed results in regards to the influence of gender and race may be confounded by many other influences within the context of the patient-provider interaction such as language, length of relationship, and site of care (Schouten & Meeuwesen, 2006). Health providers have suggested other possible sources of health disparities among minority patients both inside and outside of the patient-provider interaction such as patient's insufficient language skills, and the provider-patient relationship (O'Mahony & Donnelly, 2007). From the minority patient perspective, perceived racial discrimination on an interpersonal level has been noted as an independent predictor of the patient-rated quality of care even when factors such as language, socio-demographics, insurance, and education were controlled (Sorkin, Ngo-Metzger, & De Alba, 2010; Williams & Mohammed, 2009). Despite an increase in disparity research, the sources and actions that cause unequal treatment within the provider-patient interaction remain somewhat elusive.

The challenge in identifying relational contributions to patient-provider-mediated racial/ethnic discrimination is often limited by the ability of studies to distinguish between sources of discrimination (group-based, systems-based, or interpersonal). Group and systems-based studies of discrimination are often linked with health outcomes showing disparities when compared to the majority, the population average, or the

healthiest group (Adler & Rehkopf, 2008) and thus miss the interpersonal aspect between patient and provider. Blank, Dabady, and Citro (2004) pointed out other difficulties in studying discrimination. Reports tend to be drawn from various sources such as surveys and administrative records that lack direct observation of actual discrimination but include measures of reported experience, perceptions, and attitudes that involve discrimination. These reports may also be influenced and include a broader variety of system-based contributions such as patient access to care, insurance, educational level, and socioeconomic status.

Approaches such as large-scale surveys assess a group's aggregate understanding about the incidence of discrimination but lack the ability to indicate how disparity is constructed in interpersonal interactions. Others (Kressin, Raymond, & Manze, 2008) agree that studies are lacking that elucidate individuals' responses to racial/ethnic discrimination, therefore making it difficult to understand the significance of experiences and how these might affect health care. The Institute of Medicine report on health disparities (Smedley et al., 2002) pointed out that racial and ethnic disparities in health care are not fully explained by differences in access, clinical suitability, or patient preferences, but instead, disparities exist in the broader historical and current context of social and economic inequality, prejudice, and systematic bias. Additionally, this report noted that most studies of health disparity have centered on the routine facets of care such as receiving certain tests, therapies, and procedures; less is known about the interpersonal aspects of care that may add to disparities. Patient perceptions of clinical interactions have been acknowledged as potential mediators of racial/ethnic disparities in health reports (Sorkin et al., 2010). Studies are needed that identify the construction of

disparities within the interpersonal context. Interviews that are in-depth and semi-structured have the potential to acknowledge the experience and perceptions of disparity within a particular context such as the health encounter (Blank et al., 2004).

Another problem is in defining disparity, race, ethnicity, and culture. The definition of health disparities varies in the literature and often focuses on categories of race and ethnicity. Healthy People 2010 defined health disparities as “differences that occur by gender, race or ethnicity, education, income or disability, geographic location or sexual orientation” (p. 14). Measuring disparities has been problematic due to the intersecting influences of these differences that may skew results of empirical research (Adler & Rehkopf, 2008).

Using race as a variable in empirical studies has been problematic and limiting. Race is poorly defined and may be conceptually blurred with ethnicity, culture, or religion (Bastos, Celeste, Faerstein & Barros, 2010; Contrada et al., 2000; Culley, 2006; Fagin, 2011). Race as a category usually signifies the division of humankind into discrete groups, marked by irreversible biological characteristics; despite these outward differences, there is no genetic category for race (Fenton, 1999). Ethnicity is a term used to identify unique characteristics associated with culture and socialization (Culley, 2006). In health literature, race and ethnicity often merge as a one poorly defined concept that is often not linked to theoretical models, medical outcomes (Lee, 2009), or care received (Kressin, et al., 2008). The idea of ethnicity may imply culture or religion but very few studies have addressed religion as factor in unequal treatment (Kressin et al., 2008). Empirical studies use race and ethnicity as descriptive data to identify populations and these concepts have become a normative lens in research in order to discuss human

variation and health (Moscou, 2008). In disparities research, very few critical studies (Dossa, 2005; Laird, Amer, Barnett, & Barnes, 2007a; Padela & Rodriguez del Pozo, 2010; Pesut & Reimer-Kirkham, 2010; Williams & Mohammed, 2009) have acknowledged race, ethnicity, religion, and gender as constructs that intersect and relate to each other and include historical and political realities rather than being descriptive categories that define groups.

The vast majority of racial populations studied are categorized according to those delineated by the United States census such as African Americans and Hispanics, thus excluding a growing number of Arabs (Awad, 2010). As with any racial classification, construction of Arabs as a group is problematic. Arabs as a race or ethnicity ignores several aspects of their diversity and may draw upon popular assumptions about their identity that are influenced by the media (Mishra, 2007). As a group, they may be identified geographically, culturally, religiously, linguistically, or phenotypically; all of these fail to define them because of the differences that exists in this group. For example, Arabs vary religiously, nationally, geographically, linguistically, and culturally; they not only vary by religion, (Muslim/Christian) but within a religion (Sunni, Shia). Differences exist in the context of each nation, region, and dialect (El-Sayed & Galea, 2009). Arab Americans comprise about 3 million people who trace their identity to one of the 22 different Arab countries (El-Sayed & Galea, 2009; Samhan, 2006). Despite the tendency to equate Arab with Muslim, the majority of American Arabs are Christian and a growing number (23%) are Muslim (Samhan, 2006). Not only have categories of race/ethnicity ignored variations within groups, but they have neglected important intergroup variations and perspectives such as that of immigrants, refugees, and women (Jackson, 2010;

Kandula, Kersey, & Lurie, 2004).

Health disparities research specific to Muslim or Arabs in the United States is lacking. However, what is known comes mostly from self-reports of discrimination, where Arab or Muslim patients found medical staff to be unhelpful or patronizing, insensitive to their needs, failing to recognize variations in language proficiency, religious preference, and acculturation (Inhorn & Fakihi, 2006; Kulwicksi, Miller, & Schim, 2000; Reitmanova & Gustafson, 2008; Simpson & Carter, 2011). Although the Arab Muslim population has endured various types of racism even before September 11th, and increasingly since that time, very few studies have specified how acts of racism have influenced health care or the patient-provider relationship (Inhorn & Serour, 2011; Simpson & Carter, 2011). Even less is known about how these events may have affected recent Iraqi refugee arrivals to the United States and in particular Iraqi Muslim women as they experience the health care encounter. These unknowns leave a gap in knowledge about how the health care encounter is experienced, negotiated, and perceived by Arab Muslims who, although are greatly varied, may be enduring similar experiences of racism due to recent social and political events (Laird, Amer, Barnett, & Barnes, 2007a). Of specific interest to this research are the past and present colonial influences of the West and recent actions of the U.S. military in Iraq for certainly these have left the Iraqi refugee with concepts of Americans that may influence their daily lives in the United States. There is no doubt that these interwoven complexities of current political events, along with the intersection of race/ethnicity, religion, and gender have all impacted the experiences of Iraqi Muslim women as they have entered the U.S. context and the health care encounter.

Likewise, with these historical events in mind, it is very likely that societal discourse of Arabs and Muslims has influenced health care providers' experiences and perceptions as they care for Iraqi Muslim women; but how this influences the health care provider's care on an interpersonal level is unknown. Few studies have addressed the provider's potential role in creating conditions that foment unequal treatment (Kressin et al., 2008). Surveys fail to capture or account for the subjective experience of health care providers, which not only leaves a gap in knowledge but raises questions about the validity and reliability of these methods (Krieger, Smith, Naishadham, Hartman, & Barbeau, 2005; Ramirez, Ford, Stewart, & Teresi, 2005). Hence, research is needed that attends to the personal interaction between patient and provider. It must account for the broader context of care that includes the influence of historical, political and societal discourse, and personal conceptualizations of the other; it must discover the relational elements that dispense power and propose subjugation within the health care encounter while attending to the potentially opposing and conflated constructions of race/ethnicity, gender, and religion. By addressing these aspects, knowledge is added to the understanding of how disparity is constructed at the interpersonal level within the health care encounter.

Statement of Purpose and Aims

Experiences within the health care encounter for both Iraqi Muslim refugee women and their health care providers remain undocumented and unaccounted for in disparities research. This descriptive, exploratory study seeks to understand and uncover the relationship between patients (Iraqi Muslim women) and health care providers within

the health encounter, specifically in the context of how the intersection of race/ethnicity, gender, and religion shape the encounter. The health care encounter is defined as interactions between patient and provider that occur when a patient (Iraqi Muslim refugee woman) arrives at a medical clinic to receive medical treatment from a primary health provider (physician, nurse-practitioner, physician's assistant) that she has identified. Critical ethnography is the method of inquiry and postcolonial feminism serves as a theoretical framework to explore issues of power, subjectivity, and the intersecting concepts of gender, race, and religion within the encounter. Participants include Iraqi Muslim refugee women situated in the Salt Lake Valley and their health providers.

Aims

The purpose of this critical ethnography is to describe the perceptions and experiences of Iraqi Muslim women and their health providers in the context of a primary health care encounter.

- Aim One: Describe the individual health care encounter experiences of Iraqi Muslim women with their health care providers. This aim contains the following questions:
 1. How do Iraqi Muslim women's perceptions of the provider shape their experience of and interaction with the health care provider?
 2. How do Iraqi Muslim women describe and experience the intersection of race, gender, and religion within the context of the health care encounter?
- Aim Two: Describe the experiences of primary health providers with Iraqi Muslim women within the health care encounter. This aim has the following

questions:

1. How do primary health care providers' perceptions of Iraqi Muslim women shape their experience of and interaction with Iraqi Muslim women?
 2. How do primary health care providers conceptualize and act on intersecting concepts of race, gender and religion in the health encounter with Iraqi Muslim women?
- Aim Three: Describe how the health encounter experience for both Iraqi Muslim women and their health care providers are similar and different in regards to the intersecting concepts of race, religion and gender. This aim has the following questions:
 1. How are experiences of Iraqi Muslim women and primary health care providers similar or different?
 2. How are sources and intersecting conceptualizations of race, gender and religion for Iraqi Muslim women and their primary health care providers different and similar and how are these expressed in the health care encounter?

Conceptual and Operational Definitions

Culture is a socially constructed system of contextual influence (cognitive, behavioral, and attitudinal) that provides individuals with ways of relating and categorizing situations; but this system does not limit the individual to act within this system (Bordieu, 1990; Culley, 2006). It is important to recognize that culture is a dynamic influence that is interpreted and embodied; it is capable of adapting in order to

accommodate to new contexts (Lynam, Browne, Reimer-Kirkham, & Anderson, 2007).

Cultural competence is the ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs of patients in the health care encounter (DHHS, 2001). It may also be defined within the health care encounter as the ability of the health provider to form effective interpersonal and working relations that surpass cultural differences (Cooper et al., 2003).

Cultural safety is an environment that is secure for people and free of the fear of assault, or challenge to one's identity or to one's need. It is a place where there is shared respect, and shared knowledge; where the experience of living, learning, and working together is filled with dignity and true listening (Williams, 1999).

Discrimination is differential treatment of a person or group that causes disadvantage to the individual and group; treatment can be based on race or any other socially constructed category (i.e., religion, gender, sexual orientation, language, etc.) (Blank et al., 2004). In health care, discrimination is explained "as differences in care that emerge from biases and prejudice, stereotyping and uncertainty in communication and clinical decision-making" (Smedley et al., 2002, p. 160).

Ethnic density may be a factor in perceived discrimination and racism. Ethnic density is defined as the proportion of ethnic minority residents in an area (Becares, Nazroo, & Stafford, 2009). It is generally thought that an ethnically dense environment includes supportive communities and social networks that may mitigate the detrimental impact of racism on the health of ethnic minorities (Becares et al., 2009; Pickett & Wilkinson, 2008). For example, some have postulated that the larger number of Arabs and Muslims present in the Detroit area may have diminished reports of racism and its

psychological distress (Padela & Heisler, 2010). These researchers conducted cross-sectional investigation of Arabs in Detroit through surveys and personal interviews of 1,016 Arab American adults in Michigan and reported no increased psychological distress, nor lower levels of happiness or lower perception of health status. Nonetheless, they hypothesized that reported abuse and discrimination in itself may produce increased psychological distress. Ethnic density may likely have an impact on this study. Most new arrivals to Utah do not have a network of family or friends established in Utah nor a community of Iraqis to draw upon as is the case in larger metropolitan areas like Detroit (Lyon, 2009).

Gender includes a range of characteristics used to differentiate male and female and the traits assigned to them and can include sex, social role, and identity. Gender role can be constructed by the influences of culture and is therefore socially constructed (Haig, 2004; Udry, 1994). Gender's impact socially is intertwined with other processes such as racialization, racism, class, health, and religion (Anderson, 2000; Collins, 2000).

Health care encounter is the point where patient and health care provider meet in a clinic to address the patient's health concerns. It is further defined in terms of provider functions; relationship building, information gathering and assessment of patient problems, and managing patient problems through treatment (Cole & Bird, 2000).

Health disparities are defined by Healthy People 2010 as "differences that occur by gender, race or ethnicity, education or income, disability, geographic location or sexual orientation" (Department of Health and Human Services, 2000, p. 14). It is recognized that several definitions exist in the literature (Carter-Pokras & Baquet, 2002).

Health care provider will be any clinical provider providing primary care services

and may include a physician, physician's assistant, or nurse practitioner. The health care provider may also be referred to as the provider.

Intersectionality recognizes that social categorizations (i.e., race, religion, gender, nationality, etc.) act together and are related to each other, therefore limiting the categorization of any one social group (i.e., Iraqi Muslim women) as being similar in any aspect, such as perspective, experience, or identity (Staunaes, 2003; Yuval-Davis, 2006). This paradigm seeks to understand what is created and experienced at the intersection of two or more social locations as axes of oppression; it recognizes relational constructs of social inequality and is another tool or lens for examining how power functions in relationships (Collins, 2000). The current view of Islam in the United States is a good example of the intersectionality of race, religion, and gender that has emerged from recent political events and social discourse. The result is that brown skinned, non-Christian Americans are not only other but they become an "other" that is associated with or identified as a foreign enemy due to a presumed connection and loyalty to Islam (Joshi, 2006). Gender enters the intersection because of identifiable clothing. Visible signs of identification as a Muslim such as a head scarf or hijab, and having dark skin, has equated with non-American, others, and enemies (Joshi, 2006). The effect of this intersection is so broad that it has encompassed other minority religions and immigrants and has led to racist actions. It was reported by Allen and Nielsen (2002) that visible membership of a vulnerable group is a major determinant of racially or religiously motivated abuse.

Iraqi women are those women who are originally from the country of Iraq.

Muslim is an adherent of Islam and refers to persons who identify themselves as

following Islam as a religion, or way of life (Merriam-Webster, n.d.).

The “other” refers to all others that are seen differently than one’s self and may refer to one person, or a group; it may involve a range of differences and may view the other as devalued but simultaneously eroticized and envied or privileged (Riggins, 1997). As Riggins (1997) explains, identifying the other produces a “we” and “they” category and is a means of negotiating identity or classifying others (i.e., a minority). Outsiders tend to view others grouped into a similar category. The dominant society acting as a majority tends to articulate discourses about others who are different and often a minority. The act of distinguishing an “other” in a way that devalues them is called “othering.” Madrid (2007) reflected on being “othered” by explaining that it makes one feel different, attentive of the distinction, and aware of being dissimilar; for some it is annoying, for others it is debilitating, and still others find it damning.

Patient refers in general to a person seeking some form of medical care from a qualified health care provider.

Prejudice is defined in psychology as an unjustified negative attitude based on a person’s group membership (Dovidio, Brigham, Johnson, & Garetner, 1996). Prejudice is based on differential assumptions about the abilities, motives, and intentions of others according to their race (Jones, 2000). Smedley et al. (2003) pointed out that overt prejudice may become part of a “rational” and normative pattern of conduct that becomes discriminatory and very possibly unrecognized by the one expressing prejudice.

Race is a socially constructed category that differentiates people based on outward appearance despite its lack of scientific evidence to define actual differences (Culley, 2006; Fenton, 1999). The idea of race remains significant because of its social

and political implications and its basis for racism (Goldberg, 1993).

Racialization is the assignment of an identity on another person, a relationship, or social group who was previously unclassified (Moscou, 2008). As Joshi (2006) explained, the racialization of religion occurs when a certain set of visual features, understood in a social and historical context, is then associated with a given religion and its social traits. This intersection may results in oppression of the minority group, but paradoxically, the original source of discrimination (e.g., race or religion) becomes unclear or lost altogether. This occurs through varied ways, ultimately reducing people to one aspect of their identity that is characterized by a uniform and static view of an ethno-religious community. This results in ethno-religious oppression that has intersecting ideas of race and religion.

Racism is defined by Clark, Anderson, Clark, and Williams (1999) as “the beliefs, attitudes, institutional arrangements, and acts that tend to denigrate individuals or groups because of phenotypic characteristics or ethnic group affiliation” (p. 805). Goldberg (1993) explains that racism includes a set of postulates, images, and practices that take action in differentiating and excluding others based on many kinds of signifiers and markers. Specifically it can include many features like skin color, facial features, clothing (hijab, turban), language accents, and religious customs (Fagin, 2011). Racism is not a homogenous phenomenon but can take many forms as the context varies (Goldberg, 1993). Personally mediated racism can be intentional or unintentional. It may appear as lack of respect, suspicion, devaluation, or dehumanization such as hate crimes and police brutality (Jones, 2000). Internalized racism occurs when those who are stigmatized begin to accept negative ideas about their own abilities and worth. They may disbelieve others

who are of the same group and believe that they are not allowed to have self-expression, or self-determination but see themselves as truly limited (Jones, 2000).

Refugee is a person who has crossed a national border because of “a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country” (United Nations High Commissioner for Refugees [UNHCR], 2011a).

Religion is a personal set or institutionalized system of attitudes, beliefs, and practices (Merriam-Webster, n.d.) that are expressed and influenced by culture and society. Religions often refer to the supernatural and spiritual realm. Religion develops moral values, laws, ethics, symbols, traditions, and sacred histories that are intended to give meaning and guidance to life (Monaghan & Just, 2000).

Representation is best defined as a statement or depiction made to influence opinion or action; it can be a formal statement made against something or to effect a change, or to form an opinion (Merriam-Webster, 2011). The power of the media, in the form of news, and film has a profound impact on representation of minority groups; the media plays a major role in affective behavior. Emotions formed by the media have been shown to affect attitudes toward racial minority groups more than measures of stereotypes (Islam & Jahjah, 2001).

Stereotypes are beliefs and attitudes that people form about another group that contain a fixed mental picture that is oversimplified. The progression of stereotyping is explained whereby people use social categories (e.g., race, sex) in obtaining, processing, and remembering information about others (Dovidio, 1999; Merriam-Webster, n.d.).

The beliefs (stereotypes) and general positioning (attitudes) that people bring to their interactions serve important functions. Mostly, they help form and streamline complex or uncertain situations and give perceivers greater confidence in their understanding of a situation in order to respond effectively. People have a tendency to categorize others into social groups because of the complexity of the social environment and the limited cognitive resources to organize and manage this complexity. These categories are often based on readily apparent, noticeable similarities such as physical characteristics associated with sex or race. When people are grouped, they are seen as similar to each other, which puts emphasis on their outward characteristics rather than the contextual attributes (environment or situation) because the outward traits offer more concrete explanations about the group's actions and give a sense of predictability to the one stereotyping the group. This grouping also minimizes any differences that may exist between group members, thus making them seem more alike than they actually are, thus forming the basis of stereotype development. Also, the act of grouping people exaggerates differences between groups. Fiske (1998) points out that this is not a benign act as stereotypes grow additional dimensions (e.g., character traits) beyond original categories and can create further distortions. Also, the magnitude of the distortion increases as the group is more obviously recognized (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987).

Stereotypes tend to be biased, and may be revealed in actions and may also remain unknown to the person possessing them. Dovidio and Gaertner (1998) found that human beings classify others into homogeneous categories that are typified by outward appearances such as age, gender, and color. They pointed out that these categories

constitute biases that may be openly expressed as bigotry or may be held unconsciously even in those who embrace egalitarian principles and truly believe that they are not prejudiced.

Stereotypes are used not only to interpret behavior but also influence how information about a group is recalled; when memory of specific information about a group member is lacking, people recall information in stereotype-consistent ways (Dovidio, 1999). Likewise when opportunity to investigate and gather information is constrained, people rely on implicit attitudes that shape responses to others (Smedley et al., 2002). In addition, stereotypes guide expectations and inferences in systematic ways and often become self-perpetuating; they can produce self-fulfilling prophecies in social interactions wherein the stereotypes of the perceiver effect the interaction in ways that adapt to stereotypical expectations (Jussim & Harber, 2005). It is important to note that people do not have to be aware of their attitudes or consciously sanction stereotypes for these factors to impact their thoughts, feelings, and actions (Fiske, 1998).

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

This literature review provides a foundation for understanding the concepts, theories, and experiences that may influence the health encounter relationship between Iraqi Muslim women and primary health care providers in the United States. The research explores how the intersections of social classifications (i.e., race, religion, gender, nationality, language) form perceptions that may influence experiences in the health care encounter between health care providers and Iraqi Muslim women. Muslims have been at the forefront of much opinionated debate in the United States recently; therefore, discourse about Arab Americans and Muslims is reviewed as a potential force that may inform opinions of the ‘other.’ Additionally, the health care encounter is reviewed in light of what is known about potential sources of discrimination. Studies of Arab American experiences and studies addressing interactions between health providers and patients are reviewed in order to address factors that may influence the health care interaction between Iraqi Muslim women and health care providers. Related theories undergird perceptions and experiences that operate in the daily lives of both health providers and Iraqi Muslim women.

Political and Historical Background of Iraq

This section focuses on the situation of Iraqi women as they are located historically and politically within their national identity as Iraqis. Their characters are meshed in a matrix of influences that contribute to the complexities of their identities. Of particular importance is the influence of colonial powers that have recently impacted the health of Iraqi women and precipitated forced migration and displacement. A review of recent historical events describes the current context of Iraqi women's lives. It is important to note that long before the events of September 11th, 2001, the Middle East region has stood in a complex relation to Western political and economic practices including colonial activities for hundreds of years. Iraqi people are cognizant of this history and have formulated ideas of the West that influence personal and political outlooks (Diamond, 2005).

Colonial Powers in Iraq

Historical, political, and religious complexities form a unique context in Iraq that has directly impacted the current lives of Iraqi women. Iraqi Muslim women are not a static entity but, like the historical Iraq, represent fluid linguistic, ethnic, political, and religious diversity (Barnes, 2009; Malinowski, 2004). Like the land they inhabited, they are resourceful and resilient for all they have endured. These women and their predecessors have endured a complex history full of political challenges fueled by the colonial relations with the West who marked Iraq's boundaries, and enclosed its vast diversity of languages, ethnicities, and religions in order to consume its oil (Peretz, 2004). Several times, women have been left in the wake of both Western and local

political aims that ignored tribal allegiances and sectarian divisions that have been embedded in society for centuries (Ciment, 1996). The political and historical context of Iraqi women's lives has had a profound impact on their health and welfare.

The Iraqi Political Environment and the Effect on Women's Lives

Iraqi women's lives were directly affected by the recent Iraqi regime and the reactions it provoked in Western countries. According to the UNHCR report in 2005, the early years of the Baathist party promoted secular socialism, which granted the novelty of equal rights for men and women; these included the rights to vote, run for political office, drive, and work outside the home. Women held jobs traditionally done by men and had some of the highest literacy rates in the region; they were among the most educated and professional women in the Arab world.

From the West's perspective, it was established that Saddam Hussein was an amoral leader, markedly mistreating his people, and it was hoped he would be toppled by his own people, but allegiances and motivation never formed across Iraq's diverse ethnic and religious factions (Caldwell, 2011). The destabilizing process for Iraq had begun with the coalition-led invasion of Iraq in 1991 (Caldwell, 2011). During the Saddam Hussein era and the first Gulf War (1990-1991), nearly a million Iraqi people were displaced from their homes, to neighboring Jordan, Syria, and Yemen (UNHCR, 2005; International Organization for Migration [IOFM], 2008).

As the former regime declined, so did the situation for women and children, which was reflected in increased rates of divorce, polygamy, domestic violence, and

mortality, and a rise in mortality and malnutrition for women and children (UNHCR, 2005). Under the former regime, women were at risk for being persecuted on the basis of their family's political opinions or religious beliefs; rape and sexual assault of female family members was used to force confessions from detainees or intimidate opposition members, or to blackmail men into cooperation with the government (U.S. Department of State, 2004).

Economic sanctions imposed on Iraq further impacted women's lives. After the 1991 Gulf War, women's rights eroded as the former regime attempted to appease religious fundamentalists and conservatives by seeking their support for the regime (U.S. Department of State, 2004). Women who had been free were now forced to travel only with a male companion and, if accused of prostitution, were beheaded without legal appeal (Human Rights Watch, 2003).

In 2003, the United States invaded Iraq again, but this time, with less international support and increased controversy. The invasion was a characteristically colonial move marked by misunderstanding, poor planning, and subsequent chaos. Former Deputy Executive Chairman of the United Nations Special Commission on Iraq, Duelfer, along with Dyson (2011), have analyzed the relationship between Saddam and the Bush administration to be one of misperception from both sides; it is from this point of misunderstanding and false assumption—building that fertile ground was created for the beginning of labeling and othering. Additionally, Iraqi resentment for America increased through actions such as establishing a full-scale Anglo-American occupation that was profoundly suspect and characterized by arrogant and imperial behavior and that was poorly informed about the Iraqi context (Diamond, 2005). Caldwell (2011) concluded

from personal experience that the U.S. action was unilateral, preemptive, and based on assumptions and poorly informed intelligence; planning for reconstruction was nearly nonexistent and poorly managed, leaving the Iraqi people susceptible to a very insecure situation. Although the genuine motive for invasion may remain elusive, its consequences have reverberated and continue to do so to this present day in the lives of both Americans and Iraqis.

Beleaguered by the U.S.-led conflict, Iraq attempted to reform after 2003, but such reforms led to a more drastic decline for women. Their situation was marked by indiscriminate attacks by insurgents, threats to life for noncompliance to Islamic dress code, fear of harassment, abduction, and rape by ‘authorities,’ decreased opportunity for work, education, travel, and access to health services (Barnes, 2009; IOM, 2008). Additionally, women increasingly faced domestic violence and the possibility of honor killing (Institute for War & Peace Reporting, 2005). The term ‘honor killing’ describes the family’s right to kill their own family member in order to protect the family’s honor. Women and girls were and are at risk for being murdered if they bring shame on the family by being suspected of or actually having sex outside of marriage (including rape) and they often are not given the chance to defend themselves (UNHCR, 2005). Due to any number of horrific circumstances, many women fled their homes and may be internally displaced, waiting in a regional country, or trying to survive in a third country.

The postwar chaos has particularly compromised the security situation for women and children. Poor planning included lack of sufficient troops to control the security situation; an influx of terrorist groups and the rise of sectarian violence changed the composition of ethnically and religiously mixed neighborhoods to districts segregated

along religious and tribal lines (Caldwell, 2011; Pillar, 2006). Occupying coalition forces had insufficient people to translate, which led to further incompetency; short tours of duty severely affected information, relationships, and communication with Iraqis (Ferguson, 2008). Additionally, the United States had little awareness of the political, economic, and religious diversity of Iraq, which hampered progress towards achieving anything quickly (Caldwell, 2011). The situation was deteriorating on many levels, leading to the largest displacement crisis in the Middle East since 1948 (Barnes, 2009).

Both wars have negatively affected all Iraqi people; many are displaced within their own country or have fled as refugees to a second country. The IOFM (2008) estimated that 402,000 people were uprooted during 2003-2005 prompted by the U.S.-led invasion of Iraq in 2003. In 2006, bombing and sectarian violence led to another 1.6 million Iraqis being displaced from their homes (IOFM, 2008). The IOFM currently estimates there are 1.9 million Iraqis displaced internally and over 2 million in neighboring states, mostly in Jordan and Syria (IOFM, 2011). Whether internally displaced or as refugees, Iraqi's lives are stressed at every level as they face the unrelenting challenges of language barriers, security, accessing health care, shelter, and food coupled with direct threats to life, generalized violence, and persistent fear (IOFM, 2008). Inside Iraq, many cannot obtain work in a new location and are not protected under international law; threats to life are constant and include kidnapping, murder, sexual violence, and pillaging or destruction of property; these factors negate the possibility of returning to Iraq (Barnes, 2009; International Rescue Committee [IRC], 2010). As Barnes (2009) pointed out, many of the regional countries (Jordan, Syria, and Lebanon) have no specific legislation or manpower to deal with the formidable numbers

of refugees and have reacted by denying admission, applying increasingly restrictive entry requirements, and detaining people in violation of international standards. In some countries, Iraqis were treated as illegal immigrants and subject to imprisonment, fines, and deportation as some receiving nations have not acceded to the necessary provisions mandated for refugees or formalized any legal provisions regulating their status; being unable to work has led to their poverty.

The Struggle to Obtain Refugee Status

Many Iraqis try to apply as refugees to another country, which is a demanding ordeal and undoubtedly adds to their stress. It can take up to 6 months before getting an interview for refugee status and in this time, their money may run out and they may be forced to return to Iraq (Ladefoged, 2007). Aside from these restrictions, obtaining assistance from UNHCR requires initiative from the Iraqi person, which is often viewed as dishonorable and demeaning to their family name and this is coupled with uncertainty about their rights and fear of being deported (Barnes, 2009).

Most of the world's refugees are assisted by UNHCR, which tries to find durable solutions for people in times of crisis. Despite tremendous efforts, resettlement is offered to about 1% of the world's refugees annually (UNHCR, 2010a). Activities of UNHCR include negotiating with governments to secure uprooted people's survival by providing shelter, protection, nutrition, health care, legal assistance, and education (UNHCR, 2011b).

Iraqi refugees have experienced and continue to endure increased bureaucracy and resulting delays in this process. Activities that assist refugees and displaced people are

dependent on timely funding, which has lagged behind the swelling crisis in Iraq, and in particular the sectarian violence and bombing of the al-Askari mosque in Samarra in 2006 (IRC, 2009). The IRC report (2009) pointed out that this large-scale mass exodus from Iraq was not anticipated nor planned for, which created delays in responding that were further slowed by the U.S. government's inclusion of additional background checks specific to Iraqis; this resulted in a fresh but failed commitment to increase admission of Iraqi refugees. This same report noted that efforts were followed by struggles at the governmental level to improve the refugee process, increase Iraqi admissions, and especially to help those Iraqis who were in danger because of their affiliation with the United States or considered vulnerable such as widows, elderly, the sick, and persecuted along with ethnic and religious minorities. According to the U.S. Department of State (2011) in 2010, Iraqis were the greatest number of admissions to the United States and totaled 18,016; they primarily came from Syria, Iraq, Jordan, Turkey, Lebanon, and Egypt. An improved response to admitting refugees from Iraq in 2009 was again met with barriers in 2011 when additional security measures were added in an attempt to weed out potential terrorists (U.S. Department of Homeland Security, 2011). These enhanced requirements have led to a lengthier process and delays in getting Iraqis to the United States, resulting in a drop of resettlement numbers for 2011 (personal communication, Gerald Brown, September 27, 2011).

As politics continue to impact women's lives, it is increasingly obvious that struggles to initiate and await the process of obtaining refugee status are taxing and difficult. This process gives little recourse for hope and likely compounds the psychological stress of the violence they have fled, along with loss of property. Women

and children are particularly stressed. Many Iraqi women have been the victims of gender-based violence, rape, and marital violence (Amnesty International, 2008). Children often end up working at small jobs for the family because they are denied school admission in the host country, which requires school documents from Iraq for entrance (Barnes, 2009).

Iraqi Refugees in the United States

Iraqis face formidable challenges as they enter the United States. Not only do they carry the burden of violence, loss, and vulnerability, they also face multiple challenges in a new environment that may be both welcoming and threatening. They face the additional stress of adjustment and current US-based conceptualization of their identity. All of these aspects of adjustment appear overwhelming for any person who has endured incredible loss and the struggle to survive. As they become part of the American population, Iraqi Muslim women with refugee backgrounds join the broader discourse of Arab Americans in the media. This section includes additional aspects of the struggle as they interface with American society such as specific resettlement problems, and the negative representation of Muslims and Arabs in the media, and medical literature. Additionally, it is assumed that the historical roots of America's religious identity and the current discourse on religion and spirituality create an additional layer for their potential marginalization.

Iraqi Refugee Settlements

In 2009, UNHCR identified 85,274 “very vulnerable” (p. 21) Iraqi refugees and the United States committed to accepting 17,000 of them (IRC, 2009). The latest comparative data show the states with the highest concentration of resettled Iraqis are Michigan, California, and Texas and these states are among the 17 states that received more Iraqi refugees than Utah in 2009 (Office of Refugee Resettlement [ORR], 2009). In Utah, Iraqi refugees also accounted for the largest national group of refugees in 2009; individuals totaled 530 from 2007-2009 (Office of Refugee Resettlement, 2014). Iraqi refugees have continued to be among the top three most populous refugee groups coming to Utah and the U.S. since 2008 to the present, ranging from 9,400 to more than 18,000 resettled yearly in the U.S. and in Utah, from 99 to 252 individuals (ORR, 2014).

Resettlement Problems

Recently, the U.S. government has made efforts to increase the number of Iraqi refugees admitted to the United States but has not made adequate provisions for accommodating to their needs upon arrival (IRC, 2009). This is coupled with the current economic crisis and the severe psychological trauma suffered by many Iraqis who have lived through a history of war, poor health conditions, grief of lost loved ones, poverty, torn families, and decreased social support. A large survey of Iraqi refugees resettled in Atlanta and Phoenix was carried out by IRC (2009) where each location received over 900 Iraqi refugees in 2009. The report listed a combination of problems faced by Iraqi refugees that primarily included employment and expectations of educated Iraqis, woman-headed homes, and health.

Employment and the Economy

According to the IRC report (2009), in the past, about 80% of Iraqi refugees were able to obtain jobs within the first few months of resettlement because many come as educated professionals and jobs were more abundant. However, due to the current economic situation, many Iraqis face joblessness, the prospect of homelessness, and a resulting sense of insecurity and low self-esteem. Refugee agencies in Arizona as well as Utah have tapped thousands of antihomeless dollars to avoid evictions of hundreds of refugee families (Lyon, 2010). When the expectation of job placement according to one's educational background is not reached, many Iraqi refugees have not only been discouraged and depressed but also angry (personal communication, Gerald Brown, September 27, 2011).

Women's Struggles

Additionally, large numbers of Iraqi women head households as widows with dependent children. These women are grieving and alone, seeking employment to support their families (IRC, 2009); they are potentially vulnerable and at risk for increased stress and poor overall health (Adanu & Johnson, 2009; U.S. Committee for Refugees and Immigrants, 2009). Many women have been separated from brothers, husbands, sons, or other family members because of the delays from the additional security checks that Iraqi men are subjected to before admission into the United States (IRC, 2009). Often, jobs lack child care and social networks for child care are tenuous or not affordable (IRC, 2009). Women's difficulties in adjusting to a new country are aggravated by weak English proficiency and limited social opportunity to improve language skills, different

types of health practices and coping skills, strongly held values, beliefs, and gender roles that differ from the country of resettlement (Hyman, 2001; Reitmanova & Gustafson, 2008). These conditions along with past trauma have compromised their mental health.

In addition to the stress of the past and the present resettlement adjustment, Iraqi Muslim women have to contend with the U.S. context. This context is strongly informed by a media that has represented them in a negative light. The representation of Iraqi refugees held within American discourse is highly significant as it translates into a daily experience that refugees must negotiate as they interact with others. The next section sheds light on the conceptualization of refugees, media-informed representations of Muslims, and the spiritual/religious climate that contributes to their conceptualization as the *other*.

Conceptualizing the Iraqi Refugee in America

Despite the variety of refugees and the differences that exist in any one group, Americans attempt to categorize them for many purposes, but this may reveal more about Americans perceptions of them than the refugees themselves (Haines 2010). Categorizing by nationality assumes to be closely related to social and cultural background, but this is a wrong assumption due to many variations in language and education. Religion may be intertwined with ethnicity or ethnicity with language. “Refugees are not easily categorized through existing notions of nation and ethnicity, much less race or religion” (Haines, 2010, p. 19). This author asserts that we have a need to categorize in order to know where they fit in, and what to expect from them, and if we can trust them. Without fitting in, they raise suspicion as to their motives and risk the label such as terrorist.

These assumptions hold true for Iraqi Muslim women with refugee backgrounds whose identities do not fall into discrete social categories linguistically, culturally, ethnically, religiously, or even nationally. Nor does any one of these categories truly define any one Iraqi woman; even their experiences as refugees are as varied as their identities. From current discourse, it appears that Iraqi refugees have not fit in, and therefore have raised suspicion and are labeled negatively; they join with others identified as Arabs and Muslims in America. The importance of this identity is its potential to filter into the health care encounter, creating conceptualizations that affect the experience for both health care providers and Iraqi Muslim women with refugee backgrounds. A brief overview of Arab American representations in the media will reveal how this group has been conceptualized in the United States.

Iraqis as Arabs

In America, Iraqis fall within the larger group of Arabs who are seen as an ethnic group called Arab Americans. A closer look at this socially constructed label reveals the vast diversity of this group. Current discourse and medical literature defines this group as residents of the United States and as those who trace their identity or ancestral, cultural or linguistic heritage to one of the 22 Arab countries (Awad, 2010; El-Sayed & Galea, 2009). The majority of Arab Americans trace their ancestry to the countries of Lebanon, Syria, Egypt, Palestine, and Iraq. There is an estimated 3 million Arab Americans in the U.S. (Samhan, 2006). They have entered the U.S. in three distinct times; as Christian laborers, farmers, and merchants from Lebanon and Syria in the late 1800s and early 1900s (Erickson & Al-Timini, 2001; Nassar-McMillian & Hakim-Larson, 2003), then as

displaced persons secondary to the formation of Israel after World War II, and finally as predominantly Muslims who were highly educated professionals escaping war and political instability in their countries (UNHCR, 2011a). The majority of Arab Americans are Christian (77%) and about 23% of Arab Americans are Muslim; as adherents of Islam, they are the fastest growing segment of Arab Americans (Samhan, 2006). Many recent events such as the September 11th bombings and the building of a mosque near the site in New York have put this group of Americans under increasing scrutiny in the media (Kaufer & Al-Malki, 2009; Persson & Musher-Eizenman, 2006).

Representation of Arab Muslims in America

The representation of Arab Muslims in America creates a limited identity that may mistakenly encompass all people who resemble Arab Muslims (Joshi, 2006). Discourses of difference are acknowledged as racist according to when they serve to form social, political, and economic practices that limit certain groups of people from resources and opportunities (Wodak, 1997). Arab Muslims are represented in a negative light by popular media, and medical literature. The religious foundations of U.S. society may help fuel this environment of negative representation while the current view of formalized religion may potentially marginalize Muslims.

Arab American Muslims in the Popular Media

It has been shown that although people may hold little information about Muslims and Islam, they have definite attitudes that are based on media sources (Altareb, 1998). U.S. polls indicate that 25% to 50% of Americans hold negative views of Islam and

Muslims (Council on American-Islamic Relations, 2004, 2006; Dean & Fears, 2006) and this is largely due to the media's influence.

Media-informed concepts have continued to depict Muslims and Islam in a negative light. These portrayals were evident before September 11th, 2001 (Karim, 1997). Now, a decade later, it is obvious that this event fueled stereotyping, and promoted the idea of Muslim as enemy, and as perpetrators of terrorism (Disha, Cavendish, & King, 2011). The persistence of Americans to frame Islam and Muslims in a negative light continues on many levels and is exemplified in multiple news reports that oppose mosques being built (Freedman, 2010), interrogation of Muslims in seeking public office (Feagin, 2011), a radical Christian leader who desired to burn the Islamic holy book, the Qu'ran (Praetorius, 2011), and racial profiling on airlines (Ordonez, 2011).

The media depicting Muslims has not addressed their diversity, but instead has stereotyped them by accentuation of the extraordinary and has framed them as antagonistic, violent, and as terrorists (Jackson, 2010). Mishra (2007) pointed out that both discourse and content analysis of the Washington Post, the Wall Street Journal, and the Los Angeles Times from 1985 to 2005 revealed increased coverage of Islam with primary topics being the threat of extremist Islam and political conflict. There was marginal coverage of injustices towards Muslims and these framed Muslims in a violent and antidemocratic light. This author also noted other major themes that included fear of political Islam, and support for Western intervention to contain projected threats from extremist Islam and to save Muslim women. Women have been a pivotal focus for much of the media about Muslims.

Arab Muslim Women and the Media

Muslim women take a unique role in U.S. discourse on Islam and Muslims. A long history of colonial thought has founded the framing of the 'Muslim woman' in the Western mind and prompts the idea of Islam's patriarchal qualities and has served as a critique of Islam (Mahmood, 2005). Muslim women are often simplistically characterized as oppressed victims of Islamic traditions (Kirmani, 2011). The media has created a monolithic group that suffers a common fate without any discussion of the complexity of actual women's lives, and has used their image to legitimize misconceptions (Adely, 2008). Muslim women's apparent oppression has been linked with violent portrayal of Islam and freeing them has been used to reinforce the U.S. political agenda (Adely, 2008; Haddad, Smith & Moore, 2006). Haddad et al., (2008) deduced that this association has engendered misunderstanding and prejudice as Muslim women contend with the notion that Islam treats them as second-class citizens. These authors also pointed out that from a Western view, the headscarf worn by Muslim women has become an identifying symbol of Islamic oppression, repression, and backward thinking; it symbolizes cultural difference or cultural inferiority, and a threat to secularity.

Arab American Muslims in Medical Literature

When considering medical literature, the view of Muslims and Islam intersects and reflects the media and presents a biased view (Laird, de Marrais, & Barnes, 2007a). In a survey of medical literature pertaining to Muslims and Islam, Laird et al. (2007a) found that religious statements were over-generalized, and the dominant portrayal of Muslims was colonial in nature, characterized by being poor, rural, and refugee. These

authors surmised that biases mixed with the larger colonial/orientalist discourse of Muslims portrays them as endangering their health, creating unhealthy environments for women, holding tightly to tradition, and posing problems for the medical system. The same authors noted that research addressing health beliefs and practices of Muslim Americans are scarce and what is viewed negatively has also come from Muslim women authors.

Gathering systematic information about Arab Americans is problematic because U.S. census data does not identify religious affiliation and Arabs are not recognized as a minority group (Awad, 2010). As noted above, both Muslims and Arabs can represent a variety of national origins and grouping them together may create a narrow frame of reference devoid of the dynamic, personal, and contextual references for their various health practices. It also may present a dominant interpretation of Islam that some Muslims may not follow.

The American Context of Religion and Spirituality

Muslims in the United States exist in a social context informed by a religious history that has been dominated and defined by Christian superiority (Joshi, 2006) and therefore is likely to play a role in the dominant representation of Muslims. Not only will the context dictate the representation of Muslims but it will most likely be a force for Muslims to negotiate on a daily basis as a member of a minority religion (Joshi, 2006). The reception and perception of Islam in America is situated in a context where Christianity has been a dominant religion in the United States and in the last decades has been contested in the public arena most often by secularism, not other faith traditions

(Joshi, 2006). This author contends that historically, religious affiliation has mattered in the United States as an essential human attribute yet being a non-Christian was seen as a flaw. He also pointed out that whiteness and Christianity co-exist as an American identity to the extent that acceptance was based on both and lacking one was criteria for discrimination; this view exists today.

The current landscape of religion in the United States has the potential to marginalize Iraqi Muslim women. It is characterized by increasing diversity and change; it includes a positive though unclear view of spirituality and a negative view of formal religion. The fluidity of religious affiliation does not necessarily translate to openness toward Islam. Hill and Pargament (2003) noted that a polarization between the ideas of religion and spirituality has emerged in U.S. society. They explained that religion has become reified as a fixed system of ideological commitments that fails to represent the personal side of religious experience, making identified religion as formal, systematized, and authoritarian. Spirituality has become the preferred term that describes the individual, subjective, affective, and unsystematic expression (Koenig, McCullough, & Larson, 2001). The dangers of this polarization not only cast formalized religion in a negative light, it also ignores the social context and personal expression of the spiritual even in organized faith traditions (Hill & Pargament, 2003). Society's interest in spirituality has sidelined more formal religion, which has further marginalized immigrant groups who hold to formal religions (Reimer-Kirkham, 2009). The religious and spiritual climate of the United States is likely to play a role in how Iraqi Muslim women experience their daily lives and interactions in the health care setting; such a climate contributes to Iraqi Muslim women's view of themselves in U.S. society. The impact of multiple negative

representations of Arab Muslims in general and of Muslim women specifically is likely to contribute to the formulation of various American-held opinions, including those held by health care providers. Negative representations of Muslim women have birthed actions of racism that are evident from current experiences of Arab Americans in the U.S. context. The experiences of racism and its impact on health will be addressed.

Current Experiences of Arab Americans in the United States

Muslims have experienced racism in the United States before the events of September 11, 2001, yet this event intensified negative attitudes toward Muslims and these attitudes have been sustained (Disha, Cavendish & King, 2011; Karim, 1997). The fact that a Pew Report (2011) showed no difference in Arab Americans reporting racial profiling, offensive name-calling, or being bothered by government surveillance in 2007 as compared to 2011 speaks to the continuity of negative attitudes and racism in the U.S.

American-Arab Anti-Discrimination (ADC) has reported a continuing problem of physical and psychological attacks on American Arabs that started before September 11, 2001; these constituted hate crimes (Ibish, 2001). Additionally, the ADC reported over 700 violent incidents in the first 9 weeks following September, 11, 2001 aimed at Arabs, Arab Americans, Muslims, and those perceived to be Arab or Muslim (Ibish, 2003). Racism was evident in the removal of Arab American and/or Muslim passengers from airplanes, and Federal Bureau of Investigation and Immigration and Naturalization Service misconduct through racial profiling, stereotyping, and through detention of foreign nationals and suspension of U.S. citizens' rights without due process (Ibish,

2003).

A few studies have directly addressed racism in the Arab American population. In a poll of 505 Arab Americans, 78% affirmed an increase in profiling and one third experienced discrimination (Zogby, 2002). A study by Moradi and Hasan (2004) found that of the 108 Arab Americans surveyed, 53% reported unfair treatment by strangers because of their Arab descent, 46% reported being called racist names, 47% reported being in an argument about racists actions toward them, and 70% admitted they wanted to tell someone off for being racist. Awad (2010) found that Muslims have experienced more discrimination since September 11th than Christians and religious identification was the strongest predictor of perceived discrimination and ethnicity was the second. This author concluded that Arab Americans continue to suffer acts of racism that may be perceived as aimed at their religion or ethnicity the longer they have remained in the United States and surmised that newly arrived immigrants may attribute such acts to their 'foreign' status rather than their religion.

In light of their journey and resettlement issues, Iraqi Muslim women face formidable challenges as they enter into the social milieu of the United States; they carry opinions about the complex political past with the West, and have faced a violent, arduous journey filled with grief, coupled with severe psychological stress and a long wait to gain refugee status. This heavily-weighted past is carried into the present and into interpersonal relationships where their identity has been formalized by the media to represent "terrorist" or "oppressed woman." Their present is complicated further by society's negative perception of formalized religion, and their own loss of extended family support, economic struggles, and the extreme demands of daily adjustment into a

new society. Under this incredible burden, they enter into the health care encounter with the possibility of mental and physical health problems. Within this interpersonal health care encounter, the above issues and other complex social forces intersect within the patient and provider experience. The social and political past and present may also surface as a health problem. However, this is not all they may bring to the health encounter; like all patients, they bring various views of health and its social context. A description of possible views of health informed by Islam will help create a foundation for understanding social factors that may influence the health encounter.

The Health of Iraqi Muslim Women with Refugee Backgrounds

The health of Iraqi Muslim women is often categorized into mental and physical health. It appears obvious that both are connected by the context of being a refugee and continue to be affected by the daily resettlement process and potentially, the experience of racism. Individual health is also informed by one's conceptualization and socialization of health. This section will address health concerns of Iraqi Muslim women with refugee backgrounds and aspects of the conceptualization and socialization of health that may have bearing for many women as they enter the health encounter.

The Impact of Racism on Health

Racism is likely to have a negative impact on the physical and mental health of Iraqi Muslim women with refugee backgrounds. Ethnic and racial discrimination has been linked to both psychological and behavioral effects such as increased psychological

distress (Brown et al., 2000), increased risk for mental disease (Kessler, Mickelson, & Williams, 1999; Ren, Amick, & Williams, 1999), and poorer health status (Brown et al., 2000; Leibkind & Jasinskaja-Lahati, 2000; Williams, Neighbors, & Jackson, 2008).

Studies suggested that Arabs as a whole may be at increased risk for racism and psychological distress (Rippy & Newman, 2006) and that perceived religious discrimination may be linked to paranoia among Muslims in America (Pickett & Wilkinson, 2008). One study of immigrant women (including 9 Iraqi women) reported experiences of emotional distress during incidents of discrimination and higher anxiety levels than the general population, suggesting an increased risk for depression and anxiety (Hassounah & Kulwicki, 2007). Racism toward Iraqi Muslim women with refugee backgrounds has been reported by Clark, a mental health worker in Utah who concluded from her interactions that Iraqis are afraid because they think Americans do not like them and consider them to be terrorists (Lyons, 2009). Acts of racism are well founded and for Iraqi women, these create a tremendous potential for mental illness when compounded by the stresses of past violence, loss, and trauma.

Mental Health of Iraqi Refugees

Iraqi Muslim women with refugee backgrounds doubtless have an array of stressors that may contribute to poor mental health. According to the IRC report (2009), overall, Iraqis arrive in the United States with greater psychological trauma and poorer physical health than other refugees. In this report, a compilation of psychological symptoms from Atlanta's Center for Torture and Trauma survivors showed Iraqi's symptoms numbered among the highest when compared to other recently arrived

refugees and were characterized by depression, anxiety, and posttraumatic stress disorder.

Studies of Iraqis with refugee status in other countries have highlighted many of the same problems and have also linked self-rated health to mental and emotional stresses (Laban, Gernaat, Komproe, van der Tweel, & De Jong, 2005). In this study, multivariate logistic regression revealed that lack of work, family issues, and asylum procedure stress had the highest odds ratios for mental health problems while both female gender and residence (in the Netherlands) longer than 2 years were associated with anxiety disorders. Another study by the same authors (Laban et al., 2007) associated a long asylum procedure with higher mental health service use and drug use. Of note was the finding that the use of mental health services (provided for free to refugees in the Netherlands) is low in comparison to the prevalence of psychiatric disorders among Iraqi refugees. They also found that having one or more psychiatric disorders predicts the use of a nonpsychiatric medical specialist but does not predict mental health service use; they hypothesized that these Iraqis presented with physical rather than mental conditions but cannot explain why. In Sweden, a prospective study (Sondergaard, Ekblad, & Theorell, 2001) of 86 Kurdish and Iraqi refugees showed that a rapid integration to the labor market was associated with self-rated deterioration of health. This study also reported that the demands in daily life and family member safety in the Middle East as well as family reunification were significant issues for this group. Similarly, Clark, a mental health therapist working with Iraqis surmised that Iraqis really want to be heard and some do not feel it is appropriate to enjoy life while their relatives are struggling abroad (Lyons, 2009).

Despite the strong likelihood of mental illness, it appears that the use of mental

health services is not readily accessed and psychological issues may be reported as physical symptoms. Others have concluded that mental illness has been stigmatized in some Arab Muslim societies (Aboul-Enein & Aboul-Enein, 2010; Douki, Zineb, Nacef, & Halbreich, 2007; Hammoud, White, & Fetters, 2006; Kulwicki, Miller, & Shim, 2000). A study by Shah, Ayash, Pharaon, and Gany (2008) found that mental health services were accessed by very few women because they feared societal stigma and could not find Arab mental health specialists. In this study, some of participants reported that in Arab cultures, having psychological issues is equated with being crazy. Some Muslims may believe that one cannot be depressed if one is following Islamic tenets and therefore, antidepressants may be rejected (Hammoud et al., 2006). Others found that psychosocial support is often a community-based activity and Muslim Arab women mentioned receiving psychological and social support from relatives back at home or from other women in whom they could confide (Shah et al., 2008).

In the absence of this support, it may be possible that women have more physical symptoms and have resorted to more traditional methods of treating their conditions. Douki, et al. (2007) found that depressive and anxiety disorders in women are linked to more physical symptoms and somatization as well as recourse to traditional healings; this can often lead to misdiagnosis. A study of Iraqi refugees (Jamil et al., 2005) that included 46 men and 70 women looked at self-reported medical symptoms and conditions with mental disorders. This study revealed that Iraqi refugees with mental disorders reported more medical symptoms and higher substance abuse as compared to other Arab Americans who have been diagnosed with a comorbid mental disorder. Although unconfirmed, the authors suggested that stress, health care availability, and

discrimination may account for these reports.

The implications of mental health issues for Iraqi refugees are multiple. As Ott (2011) explained, these conditions are difficult to address; state agencies are often overwhelmed in trying to meet the significant mental health needs in a culturally effective manner and find sufficient resources for high caseloads. She added that depression can easily lead to domestic violence and substance abuse as well as the family's social standing; it can also impact the community, with a high cost to society. This situation may leave refugees undiagnosed, untreated, and further stressed, thus compromising their ability to adjust, learn English, and support their families (Northwood, 2011).

Physical Health of Iraqi Refugees

The health of Iraqi Muslim women with refugee backgrounds had been stressed physically as well by both the past and present contexts. Iraqi women have noted that their own health needs have been put aside in order to focus on survival (Saadi, Bond, & Percac-Lima, 2011). Women's health and that of their families have been characterized by malnutrition and undernutrition along with parasitic infections in the recent past due to United Nations (UN) sanctions that have limited food resources and medical supplies and later by limited water and sanitation (Mangin, 2004). Women became familiar with breast cancer diagnosis due to years of biological and chemical warfare and radiation exposure causing high cancer prevalence (Saadi, et al., 2011). Health threats persist and include infectious diseases such as malaria, cholera, hepatitis A and E, typhoid, sand-fly fever, and tuberculosis (Mangin, 2004; World Health Organization [WHO], 2011). Newly

arrived Iraqis who come directly from Iraq may be poorly nourished and suffer from chronic conditions due to insufficient food, water, medicines, shelter, and security (UNHCR, 2011c). For those coming from neighboring countries, chronic medical conditions such as tuberculosis, diabetes, cancer, and cardiovascular disease go untreated because medical care is denied unless they can pay; this results in untreated minor conditions becoming major problems (Barnes, 2009).

Data specific to Iraqi refugee health in the United States are limited to a few surveys. One report from California (Ramos, Orozovich, Phares, Stauffer, & Mitchell, 2010) considered the health assessments of 5,100 Iraqi refugees who had arrived in San Diego between 2007 and 2009. Like all refugees, Iraqis are provided with a comprehensive medical assessment within 90 days of arrival that includes a history, physical exam, mental health screening, and laboratory tests for infections. Other assessments may be done for diabetes, hypertension, hyperlipidemia, anemia, and lead poisoning. This report found that a significant number (52% of adults over 65 years old) had indications of latent tuberculosis infection, others had *giardia* (3.1%) and *entamoeba histolytica* (1.2%), and less than 1% were positive for hepatitis B, syphilis, or HIV. The report indicated that the most frequently diagnosed noninfectious conditions were obesity, hypertension, and hyperlipidemia. Nearly 40% of those screened had dyslipidemia. Of children less than 5 years old, 7.1% were acutely malnourished and nearly 30% of the women of child bearing age were anemic. In conclusion, the authors noted that Iraqis may represent a unique profile among refugees with relatively high obesity rates. The possibility of misdiagnosis is evident from this study due to previous immunizations for tuberculosis causing a false positive test and further tests are needed to

detect known parasites that are not found with routine testing.

Iraqi Muslim women with refugee backgrounds are extremely likely to enter a health care encounter with mental and emotional stress-related symptoms due to past struggles in Iraq and present racism in the United States. It is likely that mental and physical symptoms interconnect. Each woman's unique conceptualization of illness is likely influenced by a multitude of factors that are unknown to the health provider. Iraqi Muslim women may be highly influenced by their perception of Islam and its role in their daily lives. Tenants of Islam may inform the behaviors of women and their preferences and expectations in the health encounter. Health providers may be unaware of the role of Islam in women's lives, and may operate from a vastly different set of expectations than Iraqi Muslim women within the health care encounter. Poor information about the other coupled with socially established expectations may create misunderstanding during the health care encounter. The potential role that Islam plays in guiding many aspects of Muslim women's health and lifestyle is important to establish as a context for exploring health encounter experiences. The following section includes possible ways of how Islam informs the conceptualization of health, illness, and treatment. It is important to emphasize that the concepts regarding Islam and health are presented as possibilities for any Muslim and are not static norms for Iraqi Muslim women with refugee backgrounds. Also, many of these concepts are formalized from a Western view point.

Islam and Health

Conceptualizing and Treating Illness

It is possible that Iraqi Muslim women with refugee backgrounds may attribute many meanings and causes to illnesses (Kulwicki, 1996). Among Arab Muslims, causes of illness have been reported as supernatural, social, natural, and hereditary (Kulwicki, 1991); traditional causes include exposure to cold or dampness, sudden fear, emotional upset, and carelessness (Lipson & Meleis, 1983). It is possible to mix the traditional with more current ideas of illness causation. Some may believe that speaking about something evil can bring illness and the evil eye can inflict harm on a person that has recently had a good event in life, and at the same time, they would not deny the germ theory (Aboul-Enein & Aboul Enein, 2010). Illness may have spiritual dimensions, in that it can be caused by God; for some, illness may be viewed as a divine test or opportunity to purify the soul (Lair, et al., 2007b). Islam holds the belief that the human body is a gift to be cared for and is created by God (Gallager, 2005). Some may contend that body and soul are connected, which places the whole person at stake in the illness episode (Ahmed, 2000). Prognosis and cure or cause of illness can be attributed to God (Shah et al., 2008). Some Muslims will seek the opinion of a religious authority in regards to medical treatment (Inhorn, 2003).

Health Practices

Islam as a religion is a way of life for many and therefore includes many directives for health practices and beliefs; the sources for health directives may vary (Iqbal & Noble, 2009). Some Muslims may follow specific Islamic authorities who

influence the acceptance of techno-scientific development through “fatwas,” which are authoritative Islamic opinions offered by Islamic clerics who are viewed as experts in Islamic religious matters (Iqbal & Noble, 2009). These clerics can condone new practices or place limitation on some practices of medicine (Clarke, 2009; Inhorn, 2003). Not all clerics agree equally on medical matters and interpretations of written sources may vary (Inhorn, 2003; Inhorn & Serour, 2011).

Other health directives may be contained in holy writings. Islamic scriptures include the holy book, the Quran, and various “hadith,” which are sayings and deeds of the prophet Mohammad; both contain injunctions for living a healthy lifestyle (Shah et al., 2008; Yosef, 2008). Some Qur’anic prescriptions include breastfeeding for two years, promotion of personal hygiene, and avoidance of alcoholic beverages and extramarital sex (Gatrad & Sheikh, 2001), maintaining the cleanliness of food, and resorting to prayer for healing (Shah et al., 2008; Yosef, 2008). These sources also encourage Muslims to seek knowledge about illness, and to follow medical remedies by those qualified to heal (Gallager, 2005), thus opening the way for the use of science, biotechnology, and medicine (Inhorn, 2003).

The more prominent Muslim health practices have been acknowledged as both beneficial and problematic. Despite the fact that Islamic faith generally encourages a healthy lifestyle, those practices that are deemed unhealthy have been highly publicized and often politicized and have the potential to be mistakenly applied to all Muslims while allowing beneficial practices to be overlooked. The Western health care provider may be familiar with the more prominent health practices that have been identified in the medical literature. These concerns include consanguineous marriage, fasting from dawn to dusk

during the month of Ramadan, and the potential for infectious diseases when traveling to Saudi Arabia for the pilgrimage visit known as the “haj” (Laird et al., 2007a). Traditions with risk to the woman include female genital mutilation, polygamy, arranged, imposed and early marriage, the duty to be fertile, and the despair of menopause (Douki et al., 2007).

The Social Context of Health Care

The social context of health may also been seen as problematic when viewed through a Western health provider perspective. Many people from the Middle East thrive on personal relationships, rely on each other for advice, find family relations to be a priority, and have a need to know about a person and their personality for a relationship to grow (Lipson & Meleis, 1983). The family is patriarchal and the father as head is involved in medical decisions of all family members; within the family, there is little privacy but outside the family, privacy matters a great deal (Kulwicki et al., 2000; Yosef, 2008). As Aboul-Enein and Aboul Enein (2010) pointed out, these characteristics may present the father as domineering in aspects of health care for his children and wife and depict the wife as powerless and subordinate, following a traditional role. Additionally, relationships and family may take precedence over scheduled events such as clinic visits, allowing the patient to show up late or not at all. The need to guard privacy may make information-gathering more difficult for the health provider and health decisions may involve consultation with family members that may take time and produce a consensus that is not medically oriented.

As Douki et al. (2008) suggested, family relations may make women particularly

vulnerable as they play an important role in family functioning. They are usually the caretakers of any disabled members, putting their own health at a lower priority than their role in the family. This is noted by women themselves as a potential barrier to their health (Shah et al., 2008). Women are also at risk physically and mentally if they do not fulfill their obligations; those same obligations if imposed on them by the family may put them at greater risk for depression and anxiety and therefore at greater risk to be abandoned to institutionalized care, divorced, and abused (Douki et al., 2007).

Modesty and Gender

Many Muslim women follow an Islamic ethic of modesty that influences some aspects of health care. Although there is no consensus in dress codes and modesty, some contend that it remains of primary importance (Padela & Rodriguez del Pozo, 2010). Because of various ethics and laws surrounding modesty, Islamic ethics generally hold preference for health providers to be of the same gender as the patient, followed by a non-Muslim of the same gender, then a Muslim of opposite gender, and least desired is a non-Muslim of different gender (Rasheed, 2010). It is possible that in emergency situations, and complicated procedures, some Arab Muslim women may tolerate male physicians (Hammoud et al., 2006; McLean et al., 2010). A Muslim provider is recommended based on the assumption that he or she has the knowledge to discern when a medical treatment would take precedence over religious obligations (Ramadan, 2008).

Padela and Rodriguez del Pozo (2010) suggested provider-driven practices for Muslim patients based on an extensive exploration of Islamic ethics that influence the health encounter. Modesty with medical exams entails good communication about the

need to examine the body and exposing only those parts of the body that needs to be examined at the time of exam. These authors also suggest that patients have a support person in on the medical exam or nearby if they request it as some may follow the prohibition against being secluded. Physical contact that is not part of the medical exam may be interpreted as inappropriate, especially if gender of patient and provider differ. These authors suggested approaching physical contact with caution and for the non-Muslim and provider to be attentive to nonverbal cues to guide care.

In light of this background and the prominence of Islam as part of everyday life and health practices, it is important now to turn attention to the health care encounter and how it has been experienced by Iraqi Muslim women with refugee backgrounds. Few studies have addressed their perceptions and how these have formed their experiences in the health encounter and fewer have addressed the patient-provider interaction specifically. As needed, studies of Arab Americans are included to add insight to the health encounter experience.

Arab American Health Care Encounters

There are very few studies that address the patient-provider interaction and Iraqi Muslim women specifically. Therefore, information is drawn from studies of Arab Americans and others that often include Iraqi women as part of samples of mixed nationalities, minorities, religions, or genders. In general, the health care encounter may be a challenge for any immigrant. In a study of Arab American immigrants, researchers concluded that the quality of care can be compromised due to differences in language, spirituality, societal discrimination, and psychosocial health (Shah et al., 2008).

Arab American Patient Experiences

Language barriers have a profound impact on the health encounter. As explained below, language discordance has been a source of patient-provider misunderstanding, health information deficits, lack of patient disclosure of important symptoms, delays in care, and an expressed desire for culturally, ethnically, and gender congruent health care providers. A study using focus groups and including both Muslim Arab men and women of mixed nationalities identified the impact of language barriers (Shah et al., 2008). This study pointed out that language gaps represented the most profound barrier for both men and women despite the number of years they had lived in the United States. For the women, although they possessed some level of English proficiency, they preferred to speak in Arabic to their providers in order to be fully understood. Arab-speaking patients found a lack of Arabic health education materials as well as available translators. Because of an assumed language barrier, one woman was told she would not be able to receive medical care by physicians. Some women relied on family members to translate their personal health concerns and when using a male relative or translator, they refrained from mentioning gynecological issues with their health provider. The participants lacked necessary information about Medicaid and were uncertain if it covered mental health care. Language barriers were also identified among Muslim immigrant women surveyed in Newfoundland; this resulted in a deficit of necessary health information and inability to express their needs (Reitmanova & Gustafson, 2008). In Michigan, both medical staff and Arab patients identified language barriers as one of the most problematic areas during the health encounter (Kulwicki et al., 2000).

Patient-provider gender and ethnic concordance has been identified as a major

concern of Arab Muslim women for various reasons. Iraqi refugee women identified barriers to preventive breast care such as fear of diagnosis and need for a female provider, but participants noted that this was not an insurmountable concern nor was it a concern for all women (Saadi et al., 2008). Several studies have pointed out that female Muslim patients most likely prefer gender-concordant care (Hammoud et al., 2006; Inhorn & Serour, 2011; Laird et al., 2007b; McLean et al., 2010; Padela & Rodriguez del Pozo, 2010; Saadi et al., 2011). Ethnic concordance was also expressed by Muslim Arab women who indicated that they preferred an Arab provider with shared values and cultural beliefs so that they would be understood (Shah et al., 2008). Arab women in Michigan who desired a female provider indicated that this request delayed care in making appointments, and in being seen at emergency visits; it also disrupted care continuity and often required care by a nonphysician (Kulwicki et al., 2000). In Newfoundland, women reported feeling embarrassed in requesting to be clothed during an exam in compliance with their religion (Reitmanova & Gustafson, 2008). It can be surmised from the above research that primarily, Arab Muslim women prefer, like any patient, to be understood at their health encounters. The lack of attention or understanding of their needs at the health visit led to delays in care, a possible compromise in the quality of care, and embarrassment.

The Muslim tradition for women to cover the head can be a source of forming assumptions that lead to various types of discrimination. In New York, Arab Muslim women reported that discrimination was apparent to them on health care visits (Shah et al., 2008). In this focus group study, it was noted that several assumptions of health-related staff or providers were linked to the outward appearance of the head scarf. For

one woman, it became apparent that she was treated differently after wearing the headscarf, but how she was treated was not reported. Other women felt they were treated as ignorant or assumed to not speak English because of wearing the headscarf. Others reported that during the health visit, it was incorrectly assumed that they had abusive husbands because of the headscarf.

Assumptions and lack of information have been linked with stereotyping and discrimination in health care interactions. One study (Inhorn & Fakhri, 2006) of Iraqis and other Arab Americans identified health providers as being unhelpful or patronizing in the health care encounter. More specifically, Arab participants in a Michigan study identified insensitivity by medical staff to the needs of Arab patients citing patterns of stereotyping, lack of individualized care, discrimination, and knowledge deficits of dietary practices (Kulwicki et al., 2000). Additionally, medical staff failed to recognize variations in Arabs and made assumptions as to patients' language proficiency, religious preference, and acculturation. Muslim immigrant women in Newfoundland referred to nonverbal behavior of medical staff as discriminatory. Women in this study also found that their religious needs were not taken into consideration by their health providers because the providers lacked knowledge about Islam and how its requirements might impact health (Reitmanova & Gustafson, 2008).

These studies pointed out that stereotyping and discrimination can stem from assumptions based on outward appearances. From these limited studies, language and being understood were prominent concerns of Arab American immigrant patients within the health encounter. These patient observations also reinforce what is probable and possible within the health care encounter in regards to the racialization of religion and

gender and resulting stereotyping and discrimination from health providers and staff. It is also apparent that it is not just gender, religion, or race but the intersection of these constructs that formulate ideas of the other in health encounters. Further discussion of how the intersection of social constructs intermingles with the patient-provider relationship is included in the following section.

The Health Care Encounter

The health care encounter will be discussed in light of the problems identified above by Arab American patients. Current research including health provider's experiences and perceptions with patients who differ in some social category (i.e., gender, race/ethnicity, religion) is discussed in light of the presented Arab American experiences. In a search for factors that cause disparity in the health care encounters, patient-provider differences of race/ethnicity and gender have been investigated. I contend that these are not separate, discrete entities that influence the relationship between provider and patient but that it is the intersection of these social categories in addition to any combination of other factors (i.e., religion, language, and health concepts) that has the potential to produce oppression within the health encounter. The intersection of these factors will be presented in reference to the Arab American health encounter experiences in order to formulate an understanding about the possible issues that Iraqi Muslim women may face in the health care encounter.

Language and Communication Gaps in the Health Care Encounter

Communication between patient and provider is a central issue that intersects with many facets of the health care encounter. Health encounters are complex interactions between health provider and patient and involve many aspects of communication such as the exchange of biomedical and psychosocial information, rapport building, and patient engagement (Hausmann, Hannon, Kresevic, & Ibrahim, 2011). Communication skills are necessary to form a relationship with the patient and to foster success in the assessment and management of patient health problems. In an effort to improve the quality of health care, patient-centered care was defined as one of 6 key components by the Institutes of Medicine (2001). This is a multifaceted construct that is difficult to measure (Bertakis & Azari, 2011) and includes the following behaviors: understanding and confirming the patient's perspective; understanding and considering the patient within their psychosocial context; attaining a shared understanding of the patient's problem and its treatment; and forming a partnership between provider and patient wherein patients share in decisions, power, and responsibility (IOM, 2001).

The effectiveness of communication in a health encounter can be affected by many variables, including the number of visits to the same provider (Street, O'Malley, Cooper, & Haidet, 2008), and language and cultural or ethnic congruence (Blanchard, Nayar, & Lurie, 2007). De Maesschalck, Deveugele, and Willems (2011) found that communication was hindered for provider and patients when patients had limited language proficiency (enough to explain their problem but not enough to include emotions) or no interpreter. They also found that when there is a language problem,

patients will express fewer emotional cues. Nonverbal communication is also important. Hausmann, et al., (2011) found that patient-perceived discrimination was subtle and linked with nonverbal communication. The most common types of racism reported by patients came from the affective components of communication wherein the patient was feeling that a provider was not listening to them and the patient was being treated with less respect than others.

Effective communication is likely to improve the quality of the health encounter. Benefits may include improved information for the physician and perhaps less diagnostic uncertainty through communication that focuses on the patient's concerns and questions; benefits for the patient may include decreased anxiety and increased trust in the physicians who display concern and care (Fiscella et al., 2004; Stewart et al., 2000). Importantly, Street, et al., (2008) pointed out that patient-centered communication has the ability to transcend issues of race and gender when the provider is skilled in giving information, showing respect, and supporting patient involvement in the health encounter; this in turn establishes a connection with the patient that contributes to greater satisfaction, trust, and commitment to treatment.

Communication between patient and health provider is of utmost importance and in the case of an Iraqi Muslim woman may be fraught with many challenges due to language differences, and socially and culturally based expectations that each woman may bring to the encounter. When considering the potential for mental stress and illness, communication becomes crucial to the health encounter; the inability to communicate and be understood is likely to be a source of additional distress. Distress may be expressed at the encounter as physical symptoms or may be a direct result of enduring

past trauma or present racism (Douki, et al. 2007; Hassouneh & Kulwicki, 2007; IRC, 2009; Zimmerman, Del Piccolo, & Finset, 2007). Failure to address emotional needs leads to higher health service utilization (Zimmerman & Del Piccolo, 2007) and may cause patient mistrust, long-term worry, and somatization problems (Holman et al., 2008).

Patient-Provider Race/Ethnicity Concordance

The Arab American patient experience has pointed toward a desire to have health providers who are congruent ethnically and culturally (Shah et al., 2008). This may likely more accurately reflect a need for understanding and acceptance. Disparity research has not consistently linked race/ethnicity and gender to sources of discrimination (Beach, Roter, Wang, Duggan, & Cooper, 2006; Lasser, Mintzer, Lambert, Cabral, & Bor, 2005; Weisse, Foster, & Fisher, 2005; Meghani et al. 2009). Some have surmised that the providers' perceptions and attitudes towards patients are potentially influenced by a range of factors including race, gender, and ethnicity that cannot be untangled (Weisse, Sorum, Sanders, & Syat, 2001). Additionally, there is no obvious explanation as to how attitudes, biases, and stereotypes may result in differences in clinical treatment or patient care outcomes and therefore the degree of racial or ethnic disparities explained by gender or race is unclear (Safdar et al., 2009).

Some contend that ethnic and racial differences are more likely to represent differences of in health beliefs, illness, and communication between providers and patients (Street & Haidet, 2010). In regards to communication, a review of provider behavior (Schouten & Meeuwesen, 2006) showed that when communicating with

ethnically diverse patients, physicians showed less affective behavior, less social talk and rapport-building, less responsiveness toward patient offers, and fewer positive expressions. In regards to being aware of the patient's communication needs, physicians have been found lacking in knowing a patient's level of literacy (Kelly & Haidet, 2007). In regards health beliefs, a study by Street and Haidet (2011) revealed that physicians were poor at discerning patient's health beliefs but had a better grasp of the patient's beliefs when patients were more actively participated in the encounter. Also, physicians were poorer judges of patients' beliefs when patients were of a different race. The authors surmised that a better awareness of patient's health beliefs could potentially decrease gaps in understanding, and lead to better treatments that met patient expectations and needs and thus foster greater patient compliance. As for possible patient perspectives, a study of 214 patients (Street et al., 2008) found that when patients perceive similarities in personal beliefs, values, and communication with their provider, the relationship was strengthened.

Health Provider Assumptions as a Basis for Misunderstanding

The Arab American health encounter experience revealed that outward appearances of Muslim women were linked with several wrong assumptions such as English proficiency, treated differentially, assumed to be ignorant and possibly have an abusive husband (Shah et al., 2008). Joshi (2006) explains this intersection as the racialization of religion; racism alone is not the source but the intersection of race, gender, and religion are reduced into one static and negative view of an ethno-religious identity. Arab Muslim women are a particular target for this because they are the bearers

of identifying headscarves; and these becomes associated with a set of negative ideas linked with Arab Muslims. It has been reported elsewhere (Allen & Nielsen, 2002) that the headscarf worn by Muslim women was the major identifying factor that was linked with racially or religiously motivated abuse.

Intersectionality assumes that categories of social life cannot be separated but instead, interrelate; the impact of each category (i.e., race, religion, gender) is unique to each individual even if they share the same experiences (Brah & Phoenix, 2004; Staunes, 2003). The focus is on the effect that multiple forms of oppression may have without assuming these relations are predetermined on an institutional or an individual level (Hancock, 2007; Hankivsky & Christoffersen, 2008).

Oppressions may be an intersection of religion race and gender or may be singled out. As noted in studies above, religious needs were not taken into account for Muslim women and resulted in misunderstanding and insensitivity (Kulwicki et al., 2000; Reitmanova & Gustafson, 2008). Religious discrimination is difficult to address, and has seldom been addressed as a source of health disparities (Kressin et al., 2008). The clinic setting is usually seen as an institution separate from religious affiliation and religion is regarded as personal and private (Laird et al., 2007a). These authors noted that Muslim patients may find that Islam runs against dominant normative policies that are based on Protestant or Catholic models in assessing spiritual or religious needs of patients. Also, there is contrast between the Western idea that religious identity is likely viewed as a voluntary choice that forms part of a person's identity whereas for Muslims, Islam is often a comprehensive world view and identity that can encompass every aspect of their lives. Although these factors of potential discrimination may be more institutional than

personal, it is possible they could have some bearing on the Iraqi woman's interaction with her health care provider.

Due to lack of research, it is difficult to know how both Iraqi Muslim women with refugee backgrounds and health care providers experience the health care encounter. It is unclear how Iraqi Muslim women experience health care encounters as they struggle in a new social context to negotiate and to maintain life, while being challenged by lack of economic opportunity, linguistic differences, and health burdens. Nonetheless, based on the above information, there are several issues which may influence the health care encounter experience.

Conclusion

It is likely that past and present political and historical contexts will have a bearing on Iraqi Muslim women's perceptions of health providers. Being part of a population recently oppressed by an American-led war, Iraqi Muslim women will have views of American health providers that may be informed by their past experiences with Americans in Iraq or during the refugee process. These women may see themselves and other Americans in light of the racism they have endured as a result of September 11th and the dominant media portrayal of Muslims and Arabs. They may have formed a view of themselves on the basis of being "othered" in their daily experiences. They are likely to have endured the racialization of religion and negative comments due to wearing a headscarf. They may have been treated insensitively, assumed to be ignorant or oppressed or even an enemy due to their outward appearance.

Due to the past and present environments, it is very likely that Iraqi Muslim

women with refugee backgrounds are at considerable risk for mental and emotional illness. This may be expressed in any number of ways; perhaps as physical ailments or by frequent health visits. Despite the high potential for mental health issues, they may be reluctant to disclose mental or emotional concerns. The burdens that each woman bears as she enters the health care encounter is unknown, but it is likely to be a heavy burden that may be compounded by the weight of misunderstanding as she meets with health care providers.

In the midst of an incredibly difficult journey of survival out of Iraq and into the United States, Iraqi Muslim women with refugee backgrounds have the added struggles of negotiating life in a new language, and adjusting to a complex social system, securing employment, and surviving in a poor economy; all of this carried out in a context where they are viewed negatively by the media and perhaps by those around them.

This research explores the interaction between Iraqi Muslim women with refugee backgrounds and primary health care providers. Specifically, this inquiry considers the influence of societal discourse and its influence on experiences and concepts at the individual level for both Iraqi Muslim women and health care providers. Applying a postcolonial feminist framework helps to uncover conflated issues of religion, race, gender, and nationality that inform both health care providers and Iraqi Muslim women's experiences and perceptions.

At this point, the influence of gender specifically for Muslim women has not been explored within the health encounter. How female gender, race, and religion is lived and experienced by Iraqi Muslim women in the United States is yet to be conceptualized within the health encounter. It is unknown how their day to day experiences may filter

into the health encounter in the form of discrimination, stereotyping, or the racialization of religion.

How health providers currently experience Muslim women in their practices is also largely unexplored. Likewise, it is unknown if current ideas of Muslim women held by American society has influenced health provider's care of Iraqi Muslim women. It is also unknown if provider conceptualization of race and religion may fuse in regards to Muslim Iraqi women and if this has any bearing on the racialization of religion.

Significance of the Study

Although increased racism toward Muslims, Arabs and Iraqi people have been documented in other Western countries (Laird et al., 2007b) as well as the U.S. (Padela & Heisler, 2010), few studies have describe the type of racism unique to Iraqi people nor have included women's perspectives. Additionally, few studies have explored how intersecting concepts of gender, race, and religion may promote the experience of racism specific to Iraqi Muslim women within the health care encounter. Even though many studies have measured communication in the health encounter (Hausmann et al., 2011; Shapiro, Hollingshead, & Morrison, 2002; Street et al., 2008), none have explored how health provider's views and experiences of caring for various Muslim women may influence communication and approach to care. This study seeks to address these gaps in order to understand how the conflation of gender, race, and religion may create barriers in patient-provider interactions. It is proposed that the approach will be the first of its kind in exploring racism and health among this group of women with refugee backgrounds.

This study focuses on patient and provider descriptions of the health care encounter. Interviews of Iraqi Muslim female patients and health providers provide

insight into their experiences and perceptions of each other in the context of the health care encounter. This new knowledge has the potential to be used to address unseen gaps in understanding from both patients and providers perspectives. It also provides new insight into how various Muslim women conceptualize feminism and Islam in health matters and it reveals how health providers enact care that is influenced by concepts of gender, race, and religion. Additionally, this study adds insight into how conceptualizations of Muslim women are transmitted from social discourse to the health care encounter.

Knowledge gained in this study adds to the understanding of the health care interaction in several ways. It leads to more effective ways to address health concerns of Iraqi Muslim women and possibly other Muslims with refugee backgrounds in a context specific to decreased ethnic density. It brings a unique perspective from some women that give insight into specific health disparities that may be experienced by others.

Discoveries in this study open up new avenues of awareness that inform health provider education so that stereotypes will not confine the knowledge about individual patients but help guide provider inquiry into their unique identities. By providing the perspectives of various Iraqi Muslim women, knowledge is gained that can be used to help in planning and management of health initiatives designed to meet their health and social needs.

CHAPTER III

RESEARCH METHODOLOGY AND THEORETICAL FRAMEWORK

Introduction

In this research, postcolonial feminism (PCF) is the guiding theoretical framework and critical ethnography is the method. As a theoretical framework, PCF functions as a lens in order to focus on the undercurrents of the relationship between health provider and Iraqi Muslim woman within the social context of the health care encounter. As the methodology, critical ethnography uncovers sources of power and potential misrepresentation of persons within the relationship which may not be immediately apparent. In this section, I put forth the epistemology of this study and explain how PCF serves as a lens that focuses the construction of the “oriental woman.” Additionally, I will explain how critical ethnography works in tandem with PCF to uncover relations of power/subject, knowledge, and representation in the health care encounter relationship. Data collection including sources and the process of analysis and findings will follow.

Social Constructionism

Social constructionism reasons that the formation of meaning is a product of human interaction; meanings are dynamic and founded in the social and cultural context, thus influencing not only how something is seen, but what is seen, thus generating reality (Crotty, 1998). Events, history, and individual experiences work together to constitute meaning. Meanings are as varied and changing as the social and cultural environments from where they arise.

Each of us make meaning in our daily lives that is influenced by our life context, both past and present. Expression of these meanings is through language speaking, thinking, and also through actions. Iraqi Muslim women also construct meaning daily in life and hold to meanings that are dynamic and influenced by their previous environments in Iraq, refugee camps, and the U.S.

Social constructionism acknowledges that one's own culture not only declares what is meaningful, but how tightly one holds on to meanings (Crotty, 1998). Differing views of what is meaningful creates the possibility for conflicting perspectives. When society holds so tightly to prevailing meanings as to declare them 'truth' then a critical perspective is helpful to uncover the construction of widely accepted meanings (Crotty, 1998). Applying the critical lens of postcolonial feminism makes it possible to uncover meanings and how these meanings may affect others, be restrictive or serve hegemonic systems (Reimer-Kirkham & Anderson, 2002).

Postcolonialism

Conceptualizing postcolonialism begins with understanding the colonial period, which is located historically and geographically during the 16th through the early 20th centuries (Young, 2003). During this time, Western nations such as the British Empire (also the French, Spanish, and later the United States) exercised dominance in various parts of the world through the establishment of colonies in other countries. Western actions were motivated by ideologies that perpetuated a stance of dominance over geographic regions, including its resources and peoples (Young, 2003). The postcolonial era began around 1947 when anticolonial resistance led to the prospect of self-governance and the outward end of colonial rule. Despite the end to this era, Western dominated ideologies (e.g., political, economic, and military) continued until the present (Crisman & Williams, 1994).

Application of a postcolonial perspective to any situation requires consideration of the historical past as it informs the present. Western political and economic actions still retain aspects of colonialism that are evident today when, for example, a nation dominates, invades, or rapes the resources of another nation under the guise of humanitarianism or “justified” war (Crisman & Williams, 1994). It is also seen in the imbalance of global resources, the labeling of “first” and “third” worlds and is evident in political discourse (Krishna, 2009). Postcolonialism is concerned with colonial ideologies and actions. It can be loosely defined as a perspective that critically exposes “the domination of certain societies and peoples by others” (Krishna, 2009).

As Krishna (2009) pointed out, ideologies that are rooted in imperialism formed the idea of ‘orientalism.’ These ideas assumed Western superiority and dominance over

areas of the East or orient. Ideas that have influenced postcolonial thought are often linked to the works of Edward Said. His writings were one of the first to express postcolonial ideas that were later useful in analyzing Western actions of imperialism and Western identity. Said (1979) posits that the identity of the Oriental (Eastern and more specifically Arab) person was a construction of the Western mind influenced by decades of colonial dominance in order to control the easterner. The Western construction of the oriental person as someone other and someone different created an identity and representation based on false interpretation. He asserted that this fabricated idea of the ‘oriental other’ had an effect on the Westerner; it bolstered and defined Western identity, perpetuating an image of power and control. He holds that representations of the oriental continue with little change in hue, and are fueled by current conflicts between nations. Said declared that orientalism flourishes currently in its “scarcely concealed racism; its paper thin intellectual apparatus, and its lamentable jargon” (p. 322). Current research on racism identifies the “discourses of difference” to be racist when they institute social, political, and economic practices that constrain certain groups from resources (Wodak, 1997).

Although postcolonialism is often labeled as a theory, I prefer to side with Young’s (2003) description of it as “a related set of perspectives, which are juxtaposed against one another...” (p. 6). It incorporates issues of inequality attempts to inject alternative views or knowledge into the dominant ideology while seeking justice and “equitable relation between different peoples of the world” (Young, p. 7). This perspective is often referenced in its geopolitical foundations on a global level, yet it can be applied within relationships between individuals and/or individuals and institutions.

Postcolonialism can be combined with other frameworks, such as feminism, to sharpen the focus.

Postcolonial Feminism

A feminist perspective seeks to balance the contribution to knowledge by including members of society that have been ignored within hegemonic systems that exercise patriarchy (Young, 2003). Spivak (1988) pointed out that woman's voices have been silenced and therefore unheard; their voices are objects represented by someone else's discourse. She also acknowledges the multiplicity of women's voices that arise from various global perspectives and contextual roles that women assume. Inclusion of women's knowledge and their stories becomes the feminist act of research.

Like a postcolonial perspective, a feminist stance also seeks to uncover societal influences that may have suppressed or oppressed members of society (Reinharz, 1992; Schwandt, 2007). A feminist perspective aims to value women's experiences, by including their interests, rights, and practices, including their reasoning and emotion (Schwandt, 2007). Both postcolonialism and feminism are emancipatory and provide a critical eye toward sources of patriarchy and colonialism that may impact the silencing of women's perspectives.

Understanding life from the women's perspective is inherent in a feminist approach to research (Reinharz, 1992). But a woman's perspective does not define all women, even all Islamic women or all 'third world' women (Mohanty, 2003). Although patriarchal influences of suppression may seem at the heart of feminist studies, it would be ethnocentric to assume that these same influences will be identified and considered

relevant or important by Iraqi Muslim women participants. Instead, a feminist perspective becomes formed by acknowledging the legitimacy of Iraqi Muslim women's views, and deriving their concepts of feminism from their words. In contrast, Western, female health providers may offer a vastly different and perhaps an opposing view of feminism that may include multiple perspectives. A postcolonial feminism perspective provides a critical view of a predominantly Western, mainstream feminist stance and thus avoids categorizing feminism under one ethnic label and under one dominant culture thus, potentially erasing the significance of tightly held values that may be esteemed by one perspective (Nayar, 2010).

Like postcolonialism, a feminist perspective considers the context of women's lives presently and historically, taking into consideration the conditions they have endured in their life journey such as poverty, refugee camps, opportunity for education, fleeing war, oppression, and living with fear (Nayar, 2010). Aided by ethnographic methods (e.g., participant observation, field notes), the roles of the social and cultural context of participants' lives were acknowledged in the formation of personal perspectives.

This study used a PCF lens to focus on relationships between Iraqi refugee women and their health providers, in order to determine areas of dominance, misunderstanding, and perceived notions of the 'other' within the health care encounter relationship.

Postcolonial Feminist Perspective

A PCF perspective seeks to draw from the knowledge of people who have been left out of the dominant societal discourse (Racine, 2002) such as refugees, women, and Iraqi persons living in American society. Consequently, consideration of concepts of power, knowledge, and representation are pertinent to the application of a PCF framework. Additionally, when considering the health system and encounters between health providers and patients, a PCF perspective is focused on societal influences such as perception of gender, race, and religion. Each of these social constructs can be politically fired, socially influenced, and are embedded in ideologies and motivations that become lived realities affecting relations between people (Reimer-Kirkham, 2009). It is the PCF perspective that seeks to focus on these social constructs as a means of critically inspecting their influence on the patient-provider relationship in the health care encounter. Ideas about gender, race, and religion carry meaning in relationships; these can define how power operates, how knowledge is made and heard, and how each other is represented.

Power and Subjectivity

Power and subjectivity are critical actions of concern in a PCF framework and understanding how these operate within various relationships is the basis of analysis. Power and dominance can be found in relationships such as between societal institutions and its people, individuals, or political relations between countries. Power may assume an unbalanced relationship where one side dominates and the other is subjugated (Hall, 2001b).

Foucault (1980), however, explains that power does not necessarily flow from one source downward, but it circulates and permeates on all levels as in a network. Power relations are found in every aspect of social life in both private and public arenas; it may be oppressive and productive. Because it is so pervasive, it can also be subtle and unnoticed, rooted in forms of behavior or rituals and in its subtlety, it becomes part of everyday life. Foucault (1977) explains that this power works through relationships and circulates on a personal level, but also is connected with the larger society.

This subtle concept of power that permeates public and private relationships enlightens the postcolonial perspective. The context of postcolonial power moves from its original form of national power oppression to more subtle personal practices that emphasize dissimilarity, exclude, and potentially suppress or oppress others, causing them to feel strange, left out, or different than others. This power circulating through society and individuals is so subtle that as it permeates individual relationships; it becomes an everyday oppression that it may go unnoticed yet it distresses individuals. As Foucault (1977) pointed out, both power and knowledge form an individual through discourses that are both private and public; these form a history of influences that leave their mark on an individual.

Foucault provides an explanation of how power operates in society. Power is found in relationship (Foucault, 2000), assumes subjectivity, and is present in dominant social systems that are organized in a way that controls individuals (Mansfield, 2000). Mansfield (2000) explained Foucault's idea that subjectivity is the label or category that society places on an individual by those who speak and act for social institutions. Subjectivity becomes the conceptualization of ourselves as members of society and also

gives us impetus to act in socially-conducive ways and has power over us as members of society. In fact, subjectivity exists because of the power that subjugates its subjects. As Mansfield (2000) pointed out, from this perspective, the nature of subjectivity comes from “culture and power” (p. 51) and it includes relationships of power and subordination that are common to all societies. Foucault (2000) explained that power forms society’s conception of others. This form of power that applies itself to immediate and everyday life, categorizes the individual, marks him by his own individuality, attaches him to his own identity, and imposes a law of truth on him that he must recognize. It is a form of power that makes individuals subjects (p. 331).

The health care system (represented by those who administer services) in the United States is one societal institution where power may be subtly present or visible. It exercises power over people’s bodies, and plays a dominant role in the decisions of life, death, and health (Foucault, 2000). But on the individual everyday level, it may be hard to notice power.

Additionally, the health care system holds ideologies of the dominant society and in acting on these ideologies, it exercises power over those receiving health care. It is important to note that power filters through all social networks, between institutions and individuals, and is multifaceted in that it has various sources that are interconnected and that reinforce, nullify, or are superimposed by others (Foucault, 2000).

Knowledge and Representation

Knowledge is central to the dynamics of the health care encounter in two ways. First, this study recognizes and therefore validates knowledge of both provider and

patient. It may be likely that patients' (Iraqi Muslim women) knowledge is 'new' because it has not been heard previously in the dominant Western discourse. This knowledge is likely to redefine or challenge current dialogue that prevails in the health care system. Secondly, the discussion of knowledge as power is important because it defines how 'truth' is viewed and how perceptions and representations of others are formed.

Postcolonial perspective draws on both Foucault and Said in the areas of knowledge and representation (Krishna, 2009). They will serve as a guide to understanding the formation and use of knowledge as power. Knowledge is defined by those who dominate and create the knowledge (Foucault, 2000). Likewise, knowledge defines who has power, who is subjugated, and how people are represented in society (Krishna, 2009). Foucault claimed that knowledge is a form of power and that power determines the application of the knowledge by defining and asserting a 'truth' (Foucault, 1977). According to Foucault, knowledge is applied within its historical and political context and is evident in discourse that sustains a "regime of truth" (Hall, 2001a, p. 76). Said (1979) explained how scholarship of the West was driven by material and political interests and formed a "truth" about the East or Orient. This knowledge became the discourse of colonial ideologies that spoke of a dominant West over an inferior East (Said, 1979). These ideas about Oriental people (including those from Iraq), were historically and politically influenced and reinforced into a "truth" that has become a hegemonic consciousness in the Western mind to this day (Porter, 1994). According to Said (1979), this knowledge creates a false representation of non-Western people. Through this Western representation of the oriental person, a difference or "other" had been established by a dominant ideology that was grounded in history (Hall, 2001b).

Although freshly highlighted by current events, the idea of the “other” who is different from the Western majority is located in societal knowledge and discourses and acts to reinforce ideas of dominance (Porter, 1994). The act of creating an “other” in representation can signify differences in race, culture, language, or religion (Hall, 2001b).

Knowledge is derived from many sources and forms conceptualizations and representations of the Iraqi Muslim woman that are expressed in the health care setting. Exploring the effects of this conceptualization on an Iraqi Muslim woman in the health care setting is important. Her experiences of being counted as different or “othered” may formulate a concept of racism that points toward a barrier to health care. Representation and knowledge are critical components in the conceptualization of the “other” and form the basis for discriminating between people: acting differently towards them based on some aspect such as race, gender, religion, sexual orientation, nationality, or ethnicity.

A PCF framework seeks to uncover the historical and current contexts of imbalance and injustice that exist in relationships. This is accomplished by exploring power, subjectivity, and knowledge that work together to form the representation of the “other” in relationship. Expressions of these concepts are likely to be identified in the health care encounter. A PCF framework provides a lens to uncover the perceptions of health providers and Iraqi Muslim women and explore how these perceptions of each other impact the health care encounter.

Critical Ethnography

Ethnography as a methodology and method is used to describe and interpret cultural behavior and specifically, to explore meanings and perceptions of a particular

group of people (Schwandt, 2007). The process of producing ethnography includes significant time spent observing people in their social context, participating in the lives of the participants, and asking questions about the area of interest (Hammersley & Atkinson, 1995). Although the purpose of this study was not the production of an ethnographic narrative, ethnographic methods were employed to gather data from the participants. Ethnographic data collection tools used in this study included interviewing individuals using semistructured, nondirective questions, participant observation, and observations along with recorded field notes, and journaling.

The use of critical ethnography in this study is useful to focus on the consequences of every day social dynamics on a particular group of people. The intent of the research differs from ethnography by attempting to uncover and address inequalities such as prejudice or unfairness in the daily lives of a particular group of people (Madison, 2005). This method coincides with the intent of the PCF perspective by challenging established sources of power and knowledge through offering alternatives to conventional ways of thinking (Thomas, 1993). The approach necessitates looking beyond the status quo and moving toward change (Thomas, 1993) from “what is” to “what could be” (Noblit, Flores, & Murillo, 2004).

Philosophical Assumptions

Critical ethnography assumes there is a situation of injustice within a particular domain and operates on the premise of ethical responsibility by addressing the problem (Madison, 2005). Addressing how Iraqi Muslim women are viewed and their perceptions of how they are treated is embedded in moral principles of human rights such as freedom

and respect of others. Issues of power and control are suspected when injustice is suspect in people's everyday lives. Although forms of injustice may be couched in society's status quo, it is possible to identify these and move toward change if social practices are challenged with new knowledge and perspective of the oppressed (Madison, 2005).

Critical ethnography in this study steers clear of conventional ethnography's focus which traditionally attempts to describe a cultural situation. Instead, critical ethnography has political purpose as it seeks to invite an ear to hear the knowledge of a particular group and entice social change (Thomas, 1993). Critical ethnography addresses historical, political, social, and economic aspects of cultures and their agendas, and assumes that actions are influenced by power (Polit & Beck, 2006). This method suits a study of women with refugee backgrounds whose past and current histories are wrapped in politics. They have come from a colonized past and are presently situated in a country where they are likely considered not just as "others" by their outward appearance but as enemies.

Theory is used in critical ethnography to help interpret or analyze data, facilitate interpretation, and illuminate a social phenomenon (Madison, 2005). Critical ethnography combined with a PCF theoretical framework provides a double lens of critique in order to illuminate the social dynamics between Iraqi Muslim women and health providers within the health care encounter (Madison, 2005). Meanings and expressions of health care providers and Iraqi Muslim women will be analyzed for underlying representations of the other, including their knowledge, perceptions, and the influence of current discourses in each other's construction.

Locating Myself

In line with constructionism, it is important to note that one's perspective on reality is born within experiences or milieus and my background is no exception. On the outside, I am classified as a middle age, White, Christian, female U.S. citizen. The inside however is bicultural characterized by an Anglo-American and Arab identity and perspective rooted within. I have had nearly two decades (1984-2001) of transforming experiences living in the Middle East (primarily Jordan and Yemen). My identity and perspective has been formed through a life lived closely among Arab colleagues. While living and working with them for months, I was often the only non-Arab among them. In these years, it became apparent that my identity was challenged and fortified but also transformed outwardly and inwardly by functioning within and identifying with a Middle Eastern Arab culture. This included changing and responding to a new name, living (teaching, relating, dreaming) in Arabic, and adapting culturally in a willing effort to conform in aspects of dress and mannerisms. I never lived alone. I set up house and social life with peers who were predominantly European (Dutch, German, British, and Swiss). This presented small adjustments to my American perspective and English speech thus requiring further efforts to conform. All of these cultural influences converged upon me and molded my sense of identity over the years.

Upon reading Said's *Orientalism*, I realized more concretely how life in the European community and my own upbringing had formulated concepts of the "Oriental" within me. From time to time, these vague feelings of being superior to adjacent village patients were in conflict with what reality was telling me. It took more than a decade to adequately self-reflect upon identities by considering myself/ourselves and 'them.' I

concluded, in the end, that the Yemeni people had talents that we Westerners lacked and that their individual identity and personal characteristics were not tied to a nationality or a set of ideas, but to their own character influenced by their surroundings, just like me and my European colleagues.

Like all experiences and social interactions, the decades spent focusing my work in the Middle East has afforded me the ability to converse in Arabic and identify with Arabic-speaking individuals. For the most part, I have found a bond and acceptance into the Arab-speaking community primarily because of a common language and understanding of the Middle East. Most of my initial contacts in the local community have come from the patients I have encountered through clinical work as a nurse-midwife in two clinics in Salt Lake valley. I noted one Iraqi friend introducing me by her own set of credentials; stating my Arabic name, that I had spent 10 years in the Middle East, and that I speak Arabic. Acceptance into the world of Arab women is also easily accessed by being female.

In the Middle East, hospitality is highly valued and there is time to gather and socialize daily. It is typical that women gather in the afternoons to simply talk. Hundreds of visits to women's homes over the years while in the Middle East have allowed me to become quite familiar with the day-to-day life of Muslim women and also cognizant of the varied and changing perspectives they may have. Social interaction is traditionally separated by gender. The separation of gender in Yemen was evident when the women's version of an event would differ vastly from that of the men's version in both in content and vocabulary. Though most of my experience has been situated in Yemen, I had also acquired Iraqi friends in Jordan and Yemen after the first Gulf War. My 2-week visit to

northern Iraq in the summer of 1991 does little for my knowledge of Iraq but creates some familiarity with Iraqis when asked if I have been to Iraq. There is also a bond created by having traveled and lived in Syria and Jordan where many Iraqi refugees lived before coming to the U.S. From my encounters during interviews and participatory observation events, I am viewed as an American who has experienced the Middle East and above all, is welcomed because of the shared language of Arabic. I was accepted sometimes because someone in their community trusted or recommended me. As suspected, bonds were created with the women because of sharing a common language, gender, and geographical familiarity. As has been my experience in the past, I was welcomed initially as a stranger into their homes and offered to share thoughts, stories, and food that strengthened the bond over time.

Likewise, I can identify with the health providers in this study. As a primary health provider for women, I have been squeezed somewhat by time constraints and have negotiated health visits with women from culturally diverse backgrounds with the use of interpreters. I have had the pleasure of caring for a variety of women with refugee backgrounds including Iraqi and other Arabic-speaking women.

Description of Data Collection

Participant Access and Recruitment

Gaining access to Iraqi women was a challenge. Currently, there are no visibly organized Iraqi community groups or leaders (personal communication, Gerald Brown October 17, 2013). I started with Iraqi and other Arab women I had known previously and asked if they knew of any women who might like to be in this study. I also looked

into refugee service groups such as Asian Association, International Rescue Committee, and Utah Health and Human Rights that might interface with Iraqi Muslim refugee women. I was able to present some groups and individual contacts with a flyer that outlined the purpose of the research, but very few women gave a positive intent to participate and none followed through. Other Iraqi and Arab women contacts I had in the community were asked to help identify other women who would agree for an interview. This path of personal referral from other Iraqi women or through Arabic-speaking friends was fruitful. I discovered that trust and credibility was largely assumed if I was referred personally from one woman to another. Nonetheless, even with a personal referral, I found that many women who were approached by their friend agreed to be interviewed, gave a phone number to be contacted, but later were unreachable. Others responded and invited me to visit them in their homes. Some contacts were by chance where interpreters in the clinic could lead me to women willing to have an interview. I was also invited by one health provider to make contact with an Iraqi patient at their health care visit. As a participant observer, I also was invited by an Iraqi family to attend social events around baby celebrations, small gatherings of women, and holidays.

Accessing health care providers was more of a challenge. In the beginning, one physician heavily involved in refugee health services shared a list of other primary health providers (nurse-practitioners, physicians, and physician assistants) who saw a significant number of refugees. Health providers were contacted by postal mail and email. Once they responded by email, I phoned to set a time for the interview. At the end of each interview, the participant was asked for other health providers who fit the study criteria.

Informed Consent

Approval for the study was obtained from the Institutional Review Board (IRB) at the University of Utah before the study began. Informed consent followed University IRB guidelines and was translated into Arabic. Written information about the study was available in English and Arabic and my phone number was given if questions arose. For all participants, written and verbal explanations of the study were provided and time was given to ask questions and decide on participation.

In the consent process, all participants were informed of any potential risks, were assured of confidentiality and that participation was voluntary; they were free to decline participation at any time. A verbal consent was solicited for all participants. Verbal rather than written consent was felt to be important to maintain confidentiality and trust for Iraqi participants. I was able to consent Arabic-speaking women for the study by giving written information, then explaining the study, and answering their questions.

Health providers were initially contacted by both email and mailed letter and a written description of the study, was included. By email or phone, a time was arranged to meet, explain the study, and answer questions. Health provider participants were then given time to reconsider participation and verbal consent was obtained before the interview commenced.

Sequence of Data Collection

Open-ended questions were designed for both health providers and Iraqi women with consideration given to a postcolonial feminist lens and the literature review. Questions for Iraqi women were modified and translated into Iraqi dialect by this study's

Iraqi translator once he had met University criteria to participate in the study. Time and place for Iraqi women interviews were arranged by phone and the interview became the established reason for the visit. All Iraqi women interviews were conducted in their homes. Home visits were often started with food and beverages and light conversation with all family members introduced. During the home visit, the woman and any curious family members were given a written and verbal explanation of the study and the option of not participating at all or at any point during the interview. Once they agreed to participate, a paper version of the Arabic demographic form was filled out. Interviews were then conducted with prerecorded questions in Iraqi dialect. Answers and discussion were recorded digitally. The clear intention of the visit helped establish trust and to get to know the women. Repeated visits were made to those who were willing. Visits lasted from 2 to 5 hours and 2 to 3 visits were made to each woman. Interviews lasted 45 minutes to 1 hour. Field notes were taken on all visits and were written immediately after the visit.

Participating health providers were given a written IRB approved explanation of the study by initial post and email. Upon agreement to meet either by phone or in person, a verbal agreement of participation was obtained before the interview. Then a confidential demographic survey was filled out. Three interviews were conducted by phone and 6 interviews were carried out in medical offices and 1 in a cafe.

Field notes were made throughout the study time of data collection (August 2012 to August 2013). These included written notes immediately following each home visit, 3 clinics, and social events. There was opportunity for extended time waiting in clinics to connect with women or providers wherein observations were made of the staff, office

space, and physical surroundings of the waiting room. Home visits provided a rich source of data collection as observations were made about shared space, privacy accommodations and home décor, cooking supplies, family interactions, and measures of hospitality.

Sample

Participants were selected by purposive sampling. The aim of this strategy is to select participants on the basis of their knowledge or experience that is of interest to the study (Sandelowski, 1995). Purposive sampling included Iraqi women who can provide a full description of their experiences within the health encounter. Participants were also solicited on the basis of information needs as the study progressed (Polit & Beck, 2006). For example, I attempted several times to contact male health providers and nurse practitioners and physicians assistants to add multiple primary health provider perspective to the study.

The process was also iterative whereby there was flexibility in data collection and participants were added and interviews repeated or expanded for depth of information as analysis progressed in order to clarify patterns, note contrasts, and recognize differences (Miles & Huberman, 2002). For example, the question of fear was added to interviews with Iraqi women after discussing this at length with initial participants. Throughout the study, participants were obtained by asking for referrals (snowballing) from participating interviewees. This personal referral did not result in new participants all of the time but eventually it led to 15 Iraqi Muslim women participants with refugee backgrounds and 10 primary health providers.

Key informants consisted of 1 Iraqi family previously known and 2 young Iraqi physicians. These informants had resided in the U.S. between 2 and 5 years. Throughout the study, they gave ample background about the medical situation and health visit expectations in Iraq. This included detailed information on health visits, types of clinics, and financial concerns in the medical process as well as perspective on the diversity of patient's social context for medical care. Some of the woman informants also described the role of Islam in their everyday lives.

Inclusion Criteria

A sample of health care providers was selected on the basis of their willingness to participate and their experience providing primary care services to Iraqi Muslim women with refugee backgrounds in this location. After explaining the study, they were self-selected on the basis of having enough experience caring for Iraqi women to formulate ideas and opinions about negotiating the health encounter with these patients. The 10 primary health providers included 1 physician's assistant and 9 physicians, of which 8 were female and 2 were male. All provided primary health services in 4 different clinics in the Salt Lake Valley. The provider participant demographics are listed in Table 1.

Iraqi Muslim women with refugee backgrounds living in the greater Salt Lake Valley and health care providers caring for significant numbers of Iraqi women constituted the ethnographic field. Muslim women wearing a hijab or headscarf were selected because of their common religion and conformity of dress that is likely to influence their representation. Recent refugee status was selected because of their relatively fresh and on-going cultural transition to the United States within the last 5

Table 1. Health Provider Demographic Information ($n = 10$)

| Characteristic | Mean | Range |
|------------------------------------|------|-------|
| Age | 41 | 34-45 |
| Years in medical practice | 10 | 3-15 |
| Years of medical practice in Utah | 7 | 3-14 |
| <i>n</i> | | |
| Gender | | |
| Female | | 8 |
| Male | | 2 |
| Medical specialty | | |
| Family medicine | | 6 |
| Internal medicine | | 2 |
| Obstetrics and gynecology | | 2 |
| Languages spoken by providers | | |
| English only | | 6 |
| Hebrew | | 1 |
| French | | 2 |
| Bambara | | 1 |
| German | | 1 |
| Country of origin | | |
| USA | | 9 |
| Kenya | | 1 |
| Religious identification | | |
| Christian (Catholic or Protestant) | | 2 |
| Jewish | | 2 |
| LDS | | 2 |
| No affiliation | | 4 |

years or less. They were selected by their shared experience as refugees dealing with health issues and making clinic visits in the Salt Lake Valley. They were at least 18 years old or older to participate and they have attended at least one medical visit since their arrival. They volunteered to participate and were self-assessed to be stable mentally and physically for conversing effectively about their experiences in Arabic or English. The sample demographics for Iraqi women participants are listed in Table 2.

Table 2. Iraqi Muslim Women Demographic Information ($n = 15$)

| Characteristic | Mean | Range |
|--|------|-------|
| Age | 40 | 19-60 |
| Years in the U.S. | 3.4 | 1-5 |
| Number of current family members in household | 4 | 2-7 |
| <i>n</i> | | |
| Country of birth | | |
| Iraq | 14 | |
| Syria | 1 | |
| Countries of refuge before arrival in the U.S. | | |
| Egypt | 2 | |
| Jordan | 7 | |
| Syria | 4 | |
| Turkey | 2 | |
| Preferred language for interview | | |
| English | 5 | |
| Arabic | 10 | |
| Marital status | | |
| Married | 12 | |
| Never married | 3 | |
| Reason for medical visit | | |
| Diabetes | 1 | |
| Eye problems | 2 | |
| Headache | 1 | |
| Joint or back pain | 4 | |
| Kidney, bladder infection | 3 | |
| Lump | 1 | |
| Stomach pain | 2 | |
| Routine check up | 2 | |

Settings

Iraqi women were all interviewed in their homes. Hospitality is an honored Arab tradition and sharing meals is a sign of established trust. The invitation to interview was the first and foremost reason for the visit. After this, I was invited back to visit again. Homes were often well kept and decorated apartments where whole families lived. A total of 13 homes were visited.

Other settings for observing and interacting with Iraqi women and their families

included other Arab women's homes, outside in yards or parks, and in health clinics. The casual nature of sitting in a yard or park with groups of women and their families allowed a fuller view of interactions within families and communities.

Health center waiting rooms and offices were also settings for data collection. Observations were made within 3 clinics that served the refugee population and included waiting rooms, front desk staff, and clinic space. Most health providers were interviewed in offices within their respective clinics. One was interviewed in an open cafeteria space. All providers chose the interview location.

Compensation

Participants received a \$20 gift card after the interview. This was refused by most of the health care providers and some of the Iraqi women. For many, I inquired if they knew how to use it and then explained how it worked.

Data Sources

Field Notes

Field notes include inscriptions of observed social life in context (Emerson, Fretz, & Shaw, 1995; Hammersley & Atkinson, 1995). Madden (2010) breaks down field notes into two general types: shorter notes that are taken within the participant observation time and consolidated notes that made at the end of a day's work or soon after the event. The latter includes more description and may be analytical and reflexive. The majority of notes were the consolidated type put into the computer at the end of the day. Hours were spent after each visit to add details to the notes about the setting, the family interaction,

and additional comments that were not recorded in the visit. Writing during visits was not generally done due to my need to be interactive with all who were present and engaging. I also felt it would have raised suspicion to be writing during conversations at home visits. Nonetheless, I kept a small book for brief notes if the opportunity arose; these included some extensive note-taking while waiting in clinics and homes to meet participants. All field notes included memos and were compiled and coded. A notebook was kept as a log and a journal. Entries included community events, meetings, and short reflections.

Participant Observation

Observation is a key component of ethnographic work and is influenced by a vision shaped by a PCF lens, research questions, and my own experience, predisposition, and blindness. An attempt to be critical and aware of my own 'gaze' was necessary (Madden, 2010). Despite the number of years since living in the Middle East, I was aware of how comfortable it was to once again engage in conversation in women's homes. I made note of new experiences and changes on repeated visits and the concerns that were expressed by women and their family members. I also noted reflexive moments from engagement with both participant groups. With health providers, I became acutely aware of the common struggle faced in meeting time demands and diagnostic challenges presented in clinics.

Interviews

Individual interviews were semistructured and in depth. One digitally recorded interview per participant was conducted after their consent was obtained. All participants were reminded that their information was kept confidential and they were free to refrain from answering any questions. I conducted and recorded all interviews that were in English. For the 10 patient participants preferring to conduct the interview in Arabic, open-ended questions in Iraqi dialect (prerecorded by the translator) were presented from one recorder. Responses and continuing conversation was carried out in Arabic by myself and recorded on a second recorder. The study's translator took all Arabic recordings, transcribed them into Arabic, then translated them into English. Arabic and English transcripts were then checked for content and meaning by second native Iraqi translator who was fluent in Arabic and English. The research process is diagramed in Figure 1.

Translation and Transcription

In order to address the major challenges of language translation in qualitative research, Squires (2009) recommends that conceptual equivalence is maintained, credentials of the translator and the interpreter are addressed, and their roles in the research are clearly stated. Conceptual equivalence occurs when a translator provides an accurate translation by using words that convey the same concept (Jandt, 2003) even when no specific word exists in the other language. Conceptual equivalence was verified through use of the translator and verification by a second Iraqi translator who performed translation of the English back into Arabic.

The main translator for this study was an Iraqi physician who was fluent in

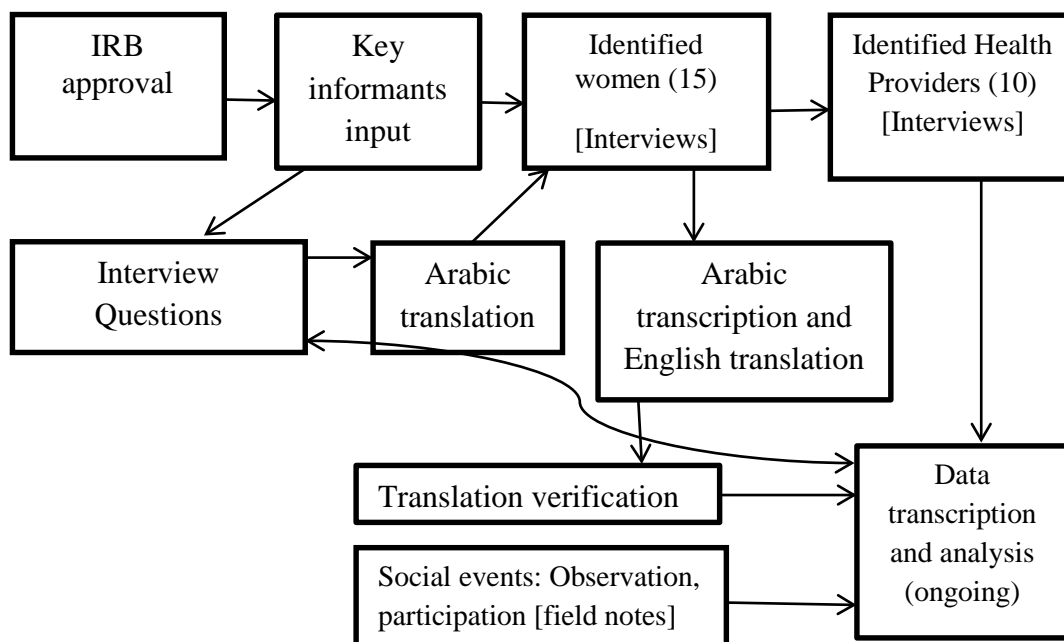


Figure 1. The research process

medical terms and familiar with health visits conducted in Iraq and in the U.S. His solid credentials were evident by his use of vocabulary, complex sentence structure, and his ability to interpret meaning when equivalent words did not exist (Squires, 2009). I determined his role and acknowledged his influence in the research (Temple, 2002). He provided not only important and accurate translation but also served as a cultural interpreter and key informant because of his intimate knowledge of the Iraqi medical environment and variations in Iraqi people and backgrounds. He also played a role in creating semistructured questions in Iraqi dialect for the interviews. We had many discussions following interview translations where he provided possible interpretations of words and phrases that may have had double meaning. Translation and transcription verification was done by me and another native Iraqi speaker who checked the Arabic transcriptions against the English translation.

Transcription of all interviews conducted in English was done by me. Audio recordings were downloaded onto the computer and played bit by bit while all words were typed into a numbered Word document. After the transcription was done, the audio recording was checked with the text and corrections made to ensure accuracy. Any names of individuals mentioned in the interview were deleted and replaced by a blank.

Potential Risks

Potential risks to Iraqi participants were primarily psychological in the form of distress by recalling incidents from their past experience that may be traumatizing. Although interview questions did not ask for recollections of traumatic events, some women or their family members volunteered stories about past events in the interview process. I carried names and numbers of counseling services with me in case these were needed. The informed consent process clarified that women could discontinue the interview or selectively answer questions as they desired. Breach of confidentiality of their information was another potential risk that may be seen as affecting their relationship with their health provider or other family members. All participants were assured that their interview was not shared in any way that would affect their health visits or relationships. They were informed of how the interviews would not be linked with any identifiable information and how they would be translated by an unknown person who was part of the research team.

Potential risks for health providers included uncomfortableness or stress in sharing their experiences with giving health care to refugees and may include frustrations, vulnerabilities, questions, embarrassments, or ideas or actions potentially

labeled as racist. They were assured that the study did not link any patients with providers and that confidentiality would be maintained, and that all recordings and demographic data were de-identified and kept secure. Likewise, they were informed that they could chose to not answer or stop participation of the interview at any time.

Protections Against Risk

Following IRB standards, the study's translator was trained through the institution's on-line program and was certified in order to understand and comply with regulations regarding human subjects. Recorded interviews were assigned a number that was not connected to any identifiable information about the participant. Along with the two translators, I had access to the transcribed, de-identified interviews for analysis purposes. Translators had no ability to re-identify the data. Only I had access to papers containing demographic data and these were always de-identified and kept in a locked office until transferred to the computer; afterwards papers were shredded. Electronic transcripts and audio recordings were stored on an encrypted computer accessible only by password and kept in a locked office. Privacy was maintained in interviews by having the participant select the area they considered sufficiently confidential for the interview. The participant always had control to stop an interview at any time. When specific names were mentioned in the interview, these were deleted upon transcription so that health providers and translators were not identified.

Data Analysis

Data analysis was accomplished through several steps and was informed by the PCF framework. In the analysis process, codes, categories, and themes along with their tracking were shared with several individuals on the research committee for feedback and comments. Before analyzing the data, I refreshed my mind with the PCF framework by reading the introduction and methods section of this document and by reviewing several book chapters and articles on this framework.

Codes and Category Development

English transcriptions of interviews and field note data were documented in Microsoft Word version 2010 and transferred to Atlas.ti© version 6.1 (Scientific Software Development, 2009). All transcribed interviews and field notes were inductively coded by starting with descriptive coding where interview text was labeled as a preliminary means to identify topics (Saldaña, 2009). As I read the interviews, I created codes based on the content of phrases. I also attached memos to specific lines of text. At the same time, I wrote reflective notes about thoughts that came to mind during the reading to record insights. I drew diagrams of how issues such as time, language, cost, and transportation were interrelated in limiting communication. Next, I printed a list of codes and with the help of notes and memos, I combined codes that were similar in content and had overlapping meanings. For example, some Iraqi participant statements under the codes “provider treatment” and “provider evaluation” were combined under the latter code. Likewise, in provider participant data, the barriers of time, insurance, translation, and transportation were grouped into the category of “patient barriers.” The

selected codes provided language that was more in line with participant perspectives and experiences that helped to illuminate the underlying issues connected to the PCF framework and research questions. In this process, initial codes for providers were reduced from 95 to 71 and Iraqi participant codes (initially 74) totaled 59. Codes that had only one or two quotes were analyzed for their meaning and uniqueness; most were excluded if they did not add new insight or were considered to contain extraneous topics.

A second focused coding of the data led to the development of categories by noting the most frequent or significant codes (Charmaz, 2006). The importance of categories was brought to light with the application of a PCF lens that considered regard for issues of power, subjugation, knowledge, and representation. The process of identifying categories took considerable time and included review of codes, corresponding text, and analytical notes while keeping in mind the broader issues in the theoretical framework. As links and comparisons were drawn between the text and the broader issues, categories became evident and were labeled. As an example, from Iraqi participant data, 'gender' was a category that emerged from the codes 'provider gender,' 'interpreter gender,' 'exceptions to gender,' 'provider awareness,' and 'feminism/freedom.' And from this data, categories were identified as barriers, communication, gender, family, expectations, and interpretation. Meaning was not in the category label so much as it was in the underlying issues that it represented. In each category, I revisited the codes and occasionally the original text to help uncover areas of power, subjugation, representation, and knowledge. I also made short notes about how these areas were expressed in selected categories. In addition, field notes and analytical notes were used to broaden and reinforce the issues in each category.

Theme Development

All codes and categories were copied to a spreadsheet and visualized together for analysis. In this format, codes were listed in a column and then moved to an adjacent column under their respective categories. I used color coding so that I could visually link common ideas among the codes and categories. I pondered the words and the issues they represented on the spreadsheet and this exercise reinforced the linkages and relationships between the categories and it helped bring broader issues to light. The main issues in each category were loosely identified as a theme, but naming the theme was not clear until I visualized a metaphor that helped exemplify the perceived issues within the data for each participant group.

Early on in the interview process, a provider mentioned that patients fell through the cracks when scheduling. In other words, there were some problems with the current system in understanding, communicating, or accommodating to the needs of Iraqi patients. The provider's statement was a metaphoric cue for me that led to a visual image of the patient who needed to cross a tenuous bridge over a foreboding chasm in order to meet the provider in a health encounter.

Metaphor use in qualitative data analysis can have multiple functions (Aubusson, 2002; Carpenter, 2008). In this study I used the metaphor of a suspension bridge to structure and interpret the data. Relational similarities between an Iraqi Muslim woman's experience in the health visit and crossing an unstable bridge over a chasm allows the reasoning in one domain to be transferred to another through inference of causes and processes (Genter, 1983). The interpretation of the data into themes was facilitated by using the suspension bridge to draw a relational similarity to the gaps and problems in the

health encounter between patient and provider. In some cases, the metaphor helped to reveal the issues more dramatically or to convey new meaning (Aubusson, 2002).

Iraqi patients were on a journey in getting health care needs met and they ran into multiple trials and barriers. An unstable bridge became a visual cue and served as an analogy of the patients' journey in getting health care; it was characterized as being unsteady and sometimes frightening. As a work of analysis and creativity, themes were formed that depicted the issues in both domains: of crossing an unstable bridge and of interacting in the health encounter. Each theme expressed a characteristic of the bridge that related to a similar issue in the health encounter. Subthemes included subtleties identified in the categories.

Themes were crafted to elucidate the issues of Iraqi Muslim women in the health encounter (crossing the bridge) and the providers' identified challenges in the health encounter with Iraqi Muslim women from their perspective on the opposite side of the bridge. The identified themes depicted each participant groups' perspectives of issues such as language, gender, religion, power, subjugation, knowledge, and identity. Aspects of the bridge domain were applicable to the provider perspective. In this analogy, the provider was viewing the bridge and the travelers (patients) on it from the distance of the health clinic situated at the opposite end of the bridge. By using the bridge metaphor, themes became images that highlighted the tasks that provider and patient faced in the health encounter.

Strategies for Rigor

Taking a constructionism view of data assumes that reality is socially constructed in context, and therefore, there is not one objective reality to be grasped by the research (Angen, 2000). Rigor is established by congruence and accountability in the research (Creswell, 2007; Pagett, 2008). The study is congruent when research assumptions, questions, data collection, and analysis match the overall purpose (Crotty, 1998; Richards & Morse, 2007). For example, following a critical ethnographic approach, research questions were modified and designed with participant and key informant inputs (Noblet et al., 2004) and reciprocity is practiced between researcher and participants in order to ground relationships in equality and exchange (Maiter, Simich, Jacobson, & Wise, 2008).

Accountability within this study is recognized by prolonged engagement, reflexivity, reciprocity, and an audit trail. Prolonged and repetitive observation is criteria for good ethnographic research (Creswell, 2007). Prolonged engagement with the participants in homes, at picnics, and social gatherings under informal circumstances will helped to build trust, expand cultural understanding, and possibly provoke less influence on participants (Ely, Anzul, Friedman, Garner, & Steinmetz, 1991; Glesne & Peshkin, 1992; Lincoln & Guba, 1985; Padgett, 2008). Developing trust and familiarity with participants developed and varied with individuals over time as I participated and engaged in conversations with the women.

Reflexivity was recorded in the research journal. It became more apparent with time as to how I both identified with participants and how my position influenced the data and analysis. Reflexivity calls upon the researcher to explore and closely examine the various influences within the social context of the participant's everyday life and the

research relationship (Fonow & Cook, 1991). My values and beliefs as the researcher are reflected and acknowledged as part of the research process (Etherington, 2007). A critical stance is apparent in the analysis and includes examining the power, privilege, and position that I held and the tension this may have created when critiquing power struggles of the participants (Madison, 2005). There were times when I was aware of my own privilege and power in society primarily through English fluency and cultural socialization at this location. At the same time, reflexivity found me identifying with health providers in acknowledging their clinical challenges, and identifying with some of their frustrations. In the research process, it was very apparent to me that I held the perspective of multiple identities (insider/outsider, health provider, observer, friend, advocate) and social positions in the research process as well as being positioned by those in the research context (Murray, 2003).

Reciprocity entails a shared negotiation of meaning and power within relationships (Lather, 1991). Meaningful exchange can take place between participants and researcher when power is explicitly addressed and equality is established (Maiter et al., 2008). This type of exchange is founded on reflexivity and functions because the researcher is aware of her social and historical positioning in relation to the research participants (Reimer-Kirkham & Anderson, 2002). At times, it was evident that reciprocity was established when conversations with participants developed into the shared position of being a patient or from previous experience as a foreigner in a new culture. Reciprocity was also evident in the acceptance of meals and gifts of food from Iraqi participants and the giving of health information and directions to local refugee resources to some participants. Reciprocity with health providers was less spoken due to

time constraints but fully acknowledged in the shared experiences and challenges of clinic work with refugees in a system that has limits of time, cultural understanding, and resources.

Reciprocity also invites participant involvement in the research process. Asking for participant's viewpoints and ideas in question construction, analysis of the data, and interpretation of their experiences also assures that participants have a credible influence in the study and own the representation of themselves (Sandelowski, 1993). Listening to participants allowed their questions and concepts to create new questions in the interview process. As themes formed, they were invited to reflect on concepts and give their opinion on these concepts.

Triangulation involves use of multiple data sources and provides corroboration and confirmation of themes and perspectives (Ely et al., 1991; Erlandson, Harris, Skipper, & Allen, 1993; Glesne & Peshkin, 1992; Lincoln & Guba, 1985; Merriam, 1988; Padgett, 2008). Data from key informants and field notes helped to confirm themes, identify diverse opinions, and produce depth to the data. Repeated visits to homes and the additional social gatherings outside the homes added depth in understanding and reinforcing cultural and individual behaviors opinions. These occasions provided another perspective that included the everyday experiences of the women and enriched the data.

An audit trail allows study procedures to be tracked; it shows a logical progression of decisions around the study's events and gives opportunity to verify findings (Padgett, 2008). The audit trail for this study included field notes with memos and self-reflective components. It also included a chronological list of interviews, meetings with participants and members of the research committee, and a progressive

coding scheme.

Limitations

There were several limitations to this study at the beginning. The most obvious includes issues around translation. The primary translator was influential in forming the concepts from his viewpoint, which may not be a perfect representation of what participants intended to convey. Iraqi women may have such high regard for health providers, and especially physicians, that they were willing to overlook some of the marginalization they received or they may have adapted to it in some way as to cope by rationalizing the treatment they receive to protect themselves. They also may have lacked a level of trust in order to fully explain incidents of overt racism, personal struggles, or poor health care encounters.

Participants were those willing to speak about their experiences. Health providers may have represented a group that was particularly interested in or partial to Iraqi refugee women's health care and may have presented a kinder view of health encounter interactions. This study may not be representative of other health provider or Iraqi women's experiences. Iraqi women or health providers with vastly different perspectives may have opted out of participation; their experiences may be very different than those in the study.

The location of this study in the area of Salt Lake City may provide a unique situation for health providers and Iraqi women since it represents a smaller diversity of ethnicities than larger cities in the United States, it is known for its kindness and is a smaller city.

Limitations also must be considered from my own influence. Although I felt I was accepted by the women I interviewed, I may have hindered full expression by my representation as an American or person somehow related to the health field. My Arabic was sufficient to carry questions into conversation during the semistructured interviews, but there may have been subtleties in the Iraqi dialect where I failed to fully understand enough to question deeper or clarify concepts and may have missed important points. As the researcher, my perspective is limited by my experiences and thoughts and this limits the interpretation and analysis of the data.

CHAPTER IV

IRAQI MUSLIM WOMEN FINDINGS

The purpose of this study is to explore perceptions and experiences of both health providers and Iraqi Muslim female patients with refugee backgrounds within the health care encounter. This chapter begins the reporting of the study findings and presents the descriptions of the health encounter from the perspectives and experiences of individual Iraqi Muslim women. Specifically, my aim is to describe Iraqi women's individual perceptions of various health providers and how this perception shapes their health encounter experience. Secondly I will address the intersection of differences (race, gender, religion, language) perceived by individual Iraqi women when with their health care providers. I use a postcolonial feminist lens in my analysis and interpretation to uncover relational concepts within the patient-provider encounter such as power, knowledge, representation, subjugation, misunderstanding, and conceptualization of the other. My findings are based on an analysis of interviews and observations with Iraqi Muslim women with refugee backgrounds and discussions with key informants. Pseudonyms are given for all individuals.

During analysis, it became apparent to me that themes from these data rest meaningfully on an analogy. A bridge came to mind as an analogy for patient and provider meeting in the health encounter. This resulted from provider interviews where

barriers caused Iraqi Muslim women's appointments to 'fall through the cracks.' First, I will explain the bridge analogy in order to establish its context and purpose and then themes will be discussed in relation to this analogy.

Bridges function to facilitate crossing usually over an obstacle or a divide. Bridges are common in every culture and can be discussed in terms of location, construction, and symbolism. The idea of crossing a bridge is located in Islamic culture and would also ring true for women versed in Islamic teaching. The most common reference to a bridge in Islamic culture is the *Sirat* in the Quran. Although there are several prophetic interpretations, according to Shaykh Abu, there is a bridge over hell that all of mankind will encounter in an attempt to enter paradise; crossing is accomplished by fulfilling specific Islamic religious obligations like prayer and is fraught with the unexpected will of God and the fear of falling into the abyss of hell (n.d., al-islam). This reference offers a parallel with the bridge analogy for patient-provider health encounters as it carries the idea of effort and fear in crossing with good to be received upon crossing.

The health care encounter between an Iraqi Muslim woman and a local primary health care provider resembles a suspension bridge over a deep gorge. It is important to note that one end of the bridge starts in Iraq where Iraqi women find their footing in the local context of their health visits. This part of the bridge is well established and founded in their histories; it is solidly built with local stone. This portion of the bridge is referenced by Iraqi women, but it is remote from our immediate vision and sits in the recesses of the horizon. As the bridge reaches the local U.S. context, it has become unfamiliar to the Iraqi women and has changed composition. It has transitioned from

solid stone to an unstable suspension bridge that is built of two sets of parallel cables that span a formidable chasm. The lower set of cables supports and connects the bridge's foot bed composed of loose and partially missing wooden planks; it is an essential but poorly constructed platform that crosses from one side of the deep chasm to the other. The upper set of cables provides a place for hands to steady the passenger who treads across the swaying and unsteady bridge. Suspension bridges are not stable, but they swing with the weight of those moving across the bridge and with the sudden winds that occur in the gorge.

For this analogy, the Iraqi woman as patient has traveled a distance on the bridge that started in Iraq and she now finds herself on an unfamiliar part of the bridge that extends into the U.S. It has transitioned into a suspension bridge that extends over a steep gorge. The gorge represents the U.S. health system with its unfamiliarity and surprises that provoke confusion, frustration, and fear. Her journey takes her into an unknown cultural environment. Past health experiences are not necessarily a reliable reference for this crossing. The familiar ways of crossing in Iraq are distant and do not apply to this new type of structure. Nonetheless, she will attempt to cross the bridge and meet the health provider who is located at the other end. There is no alternative bridge and only this one will connect her to her health provider who waits in a clinic at the other end. The health encounter rests on her ability to cross by negotiating multiple challenges.

The bridge depicts the challenges in meeting the health provider and individual Iraqi women's efforts in accomplishing this goal. Some women have skills or experience in making the journey; others lack skills and need significant support. Loose or missing planks, the bounce of other travelers, and blowing wind represent challenges and

potential barriers that face the women as patients; these barriers and challenges are differences labelled as ‘culture’ (language, norms, values, religion, etc.) and must be negotiated if the patient is to cross successfully. Although some women recall instances of health providers who attempt to give assistance, the focus of this chapter is on the women’s precarious journeys in obtaining health care services. This analogy will be used to organize, relate, and discuss the findings.

Themes

Three themes emerged from Iraqi Muslim women’s interviews, and were supported by field notes, key informants, and observational data. The themes were identified and strengthened by the repetitive nature of their occurrences. The theme ‘unheard calls for help’ included issues about communication. Within this theme, 3 subthemes arose: (a) unheard and interpreted words, (b) voiced gender choice, and (c) cries to the provider. The second theme, ‘unsteady crossing,’ included Iraqi women’s conflicts that arose out of unmet expectations in the health encounter. This theme encompassed four subthemes: (a) maintaining a perilous balance with missing planks, (b) unexpectedly gagged, (c) uneasy footing, and (d) a successful crossing? The third theme, ‘repairing and reinforcing the bridge,’ included ways that Iraqi women expressed their identity, procured support, and evaluated health provider responsiveness to participant’s cultural differences. This theme included three subthemes: (a) strengthening the cables, (b) fortifying identity to reinforce the bridge, and (c) seeing to the other side

Unheard Calls for Help

The first theme illuminates the communication barriers that Iraqi women have expressed in negotiating the health care encounter. Many of the communication barriers stem from language and cultural differences between patient and provider while other barriers are a reflection of the health system. The barriers and issues surrounding communication come from the perspective of individual experiences that collectively reflect the theme of unheard calls for help. Within this theme, participants voiced that they were not heard in regards to the interpreter, to requests for gender-congruent care as conventional gender roles and expectations affect communication, and in contacting the provider when needed. In order to understand the context in which these themes are interpreted, I will first provide background information.

Communication has been noted as one of the most important elements of the health visit. Effective communication is necessary for the exchange of biomedical and psychosocial information, rapport building, and patient engagement (Hausmann et al., 2011). Communication that fails within a health visit can lead to patient dissatisfaction, incorrect diagnosis, and multiple types of misunderstanding between provider and patient (Bertakis & Azari, 2011). In a bilingual exchange, the communication becomes increasingly complex and challenging. Consequently, the reliance for both parties on the skills of the interpreter is a critical piece among others that will determine the effectiveness of information exchange in the health visit.

Upon arrival to Salt Lake City, refugees are assigned to an agency with case workers who are responsible to arrange medical appointments, assign an interpreter, and provide transportation to the medical office. These services are negotiable and often are

not needed depending on the refugee's English proficiency, and the availability of family members who can drive or translate. For example, a woman may prefer a family member to drive but require interpretation so she may arrange to meet the interpreter at the visit. According to the woman's needs, from the time of arrival and for several months following, the interpreter is assigned the job of transporting the patient from their home to the medical office and back. At the visit, the patient also relies on the interpreter for timely check in, filling out forms, arranging any follow up appointments, and interpretation between English and Arabic during the clinical visit. The interpreter is also dependent on the clinic system, the organizational management of the agency, and the timeliness of the medical system to achieve the best result for the patient. In this context, the interpreter is assigned multiple tasks that are like a set of complex movements that must be negotiated skillfully for communication to occur between provider and patient.

Unheard and Interpreted Words

Many women relied on the interpreter for transportation to the health visit, understanding of their medical situation, and for negotiating the health system. Non-English speaking women relied on the interpreter to be heard. Despite the critical role of interpretation, women's words may still be garbled, distorted, or incomplete. Participants realized the importance of the interpreter's role and elaborated on the multiple ways that it functioned or failed. Women surmised that the interpreter functioned well, because she was trusted, timely to visits, and had an understanding of the woman's medical history. In regards to a trusted interpreter, Mariam remarked,

I'm thankful to Allah that the interpreter who accompanies me is innately secretive and she doesn't ask a lot. She just does the translation and it is important

that she knows me and understands my medical condition... she is trustworthy. A trusting relationship is explained by Kareema, “We don’t deal with people we don’t trust” and “it is an internal feeling telling us that the interpreter is honest... the interpreter has to be a friend with the patient.” She pointed out that it was important that the overall functioning of the interpreter matched the expectations of the patient so that she felt comfortable and this in turn reduces barriers that could exist between them. To be known by the interpreter was another important aspect that creates an alliance between patient and interpreter. Sarah explained, “I prefer that the interpreter knows at least basic things about me so that she would be able to answer some of the questions that they ask.” This alliance was evident when women were asked about their experiences using a computer or phone for interpretation. As Fatima expressed, “Yes, it [computer as interpreter] is the same but when the interpreter is near you, it is better.” It is evident that the expectations of a good interpreter go beyond communication and include confidentiality, familiarity, and support.

Several women were dependent on every step of the interpreter’s role in order to accomplish the expected health visit. A misstep in one aspect of the interpreter’s multifaceted role often thwarted the attempt to have a health care encounter and left the woman’s health concerns unheard. When this happened, women expressed great disappointment. Many women shared stories of being late to their appointments because of poor time management of the interpreter or the agency in organizing the visit. When the interpreter did not drive, patients had to find alternative methods for getting themselves to the visit by negotiating public transport or asking a family member to leave work to provide transportation. For Khadija, the interpreter’s service was withdrawn from

the agency, leaving her dependent on her family to find both transportation and interpretation at the clinic visit. She explained,

We are new here and not familiar with the roads. In the past the interpreter has driven us from home to the clinic. Now they are telling us that we have to go to the clinic by ourselves and the interpreter will be waiting for us there. How can we go to the clinic and we don't know the directions?

Sometimes the interpreter did not meet the woman for the visit as expected and the visit had to be cancelled. Nur explained,

The interpreter had three clients at the same time and that forced the gynecologist to cancel my appointment... the doctor was responsible because she was late seeing another patient and since the interpreter had other obligations, when my turn came, the interpreter was not available.

Using an interpreter can be a frustrating necessity that leaves gaps in communication and the patient's message may be incompletely expressed. Nur shared her opinion of using an interpreter, "I feel this way is inefficient in conveying the idea to the physician as compared to if we were talking directly. The picture might not be conveyed appropriately." Fatima, who worked as an interpreter, summarized the impact of language, "Many women have a problem with the language. You can't believe how much they suffer or how they suffer and for the most part it is because of the language." It is fair to surmise that despite the best interpretation, the message patients desire to convey is often distorted or incomplete; they are not heard.

Interpreters were also assigned to clinic visits when they were not needed. Two Iraqi women who are fluent in English recall that they arrived at the visit and were surprised to meet an interpreter assigned to their visit. Both women surmised this happened because of their last name. Naama, who is fluent in English and makes her own appointments, recalled, "Sometimes when I call they ask if I speak another language

because they see my name and I say, ‘yes, Arabic’ and then they didn’t ask if I need a translator but when I go to the visit, the translator is there.”

Voiced Gender Choice

As discussed in the medical literature, it is a well-known and common practice that Muslim female patients may prefer a female provider and interpreter at health visits. Participants expressed differing opinions as to gender preference and this was often explained by the type of visit. They also recalled instances where their requests for a female provider or interpreter were not heard. Iraqi participants generally voiced preference for gender-concordant care but also explained why this was important. This section addresses the explanations for preferences and ways in which gender preference was not heard.

Iraqi participants overwhelmingly preferred a female interpreter but often were willing to have a male interpreter if their health issue was not gynecological. Nafeeza explained that the presence of a male interpreter may also inhibit her expression of health issues at the visit,

It [male interpreter] is not a problem for me, but if I have a gynecological condition, then I will feel shy of him. In such a situation, I will need a female interpreter. If he was a male interpreter, I might not speak about my gynecological issues in his presence even if I do have one.

Nafeeza added to this idea by saying, “...sometimes they embarrass us by a male interpreter. There are things we can’t talk about in front of a male interpreter.” Clearly, female interpreters helped women to communicate.

The preference for a female interpreter is not limited to gynecological issues. Ibtisam explained that she would refuse a male interpreter and that “...a female

interpreter is more comforting psychologically.” In contrast, at a dental visit, or “a normal visit,” several women explained that it was acceptable to have a male interpreter.

Often the interpreter is assigned and there is no choice, while at other times, the woman may ask for a female yet a male interpreter is at the visit. In this regard, Nur explained her experience as “... another problem that we are suffering from.” She stated, “Every time I set up my medical appointment I ask them to provide a female interpreter. My female interpreter sometimes calls me at the last minute to tell me that she will not be there, and instead they arrange a male interpreter for me.” Like Nur, many of the women experienced the awkward surprise of having a male translator assigned to them upon arrival at the clinic visit. Hussana explained,

I went to the appointment and there is the guy waiting. He is like, are you Hussana? I am like, ‘yes.’ He is like, ‘I am here to translate.’ I am like, ‘No I don’t need it.’ And he is like, ‘No, sorry I am here to translate.’ And I say ‘sorry, I don’t need it.’ And he was there the whole time; it was so awkward! The guy just sat there and my Dad was like (sighs). He was answering the doctor for me.

A provider who is of the same gender was a preference expressed by most women, but a male provider was not a problem for some women, depending on the reason for the health visit. Naama explained, “Any physician will be fine for me; the most important part is that he/she gives me the right treatment because I am sick.” She also felt that a female physician would understand her better than a male physician, “especially with issues where one might feel embarrassed to talk in detail about to a male physician.” Although most women preferred female providers, reasons for this varied. Some expressed it as a cultural/religious teaching. Nur explained, “We women always prefer a female physician even if the reason behind the appointment is not a gynecological issue; it is for both religious reasons and comfort.” Fatima agreed with this

and said, “It is inconvenient to have a male physician. I like to talk freely with a woman; this is kind of because religion or culture.” Nafeeza expressed it in light of her background and said, “Yea, it is awkward, we are covered all of our lives and when we have a problem to go to a male doctor to the most private place, no way.” Sarah stated, “As women we prefer a female physician, and our preference is sometimes an obstacle.” Howa experienced this obstacle when she waited for an ultrasound. She had to wait for a female provider to do her exam and explains, “...this made me wait longer but it was fine.” Likewise, Huda requested a female when making her breast ultrasound appointment, but when she arrived, a male provider was her only choice. To avoid being seen by this male provider, she was given the choice to wait over 3 hours for a female provider. She did not want to wait and responded, “So I told him, ‘I don’t have any other choice. Do it to me.’” Nafeeza surmised that her request for a female provider was misinterpreted and said, “I asked if I could get a female nurse [for the exam] and he [male nurse] thought I had personal problems with him but that wasn’t it...It’s not that you don’t like them it is just that it is more comfortable.”

Cries to the Provider

The third part of the theme of being unheard includes the Iraqi women’s experiences of being unable to connect with their provider for various reasons. The factors that prevented a patient-provider encounter are unheard partially due to the persistence of health system barriers that thwart the possibility of direct communication or the possibility of achieving a health visit due to communication barriers. Imposed time limitations can have an added impact on patient communication and thwart attempts to

connect with the provider. Scheduling is time sensitive and leaves the patient waiting with an unaddressed medical problem until the distant appointment can connect them to the provider. Once patient and provider are engaged in the health encounter, communication is pressed by time. Interpretation requires additional time, and time may limit full explanation and curtail advice that may help the patient. As time intersects with communication, it creates a formidable barrier to access an effective health encounter.

Scheduling as a system barrier also causes problems in reaching the provider in a timely manner. One woman reported that her health issue resolved by the time the appointment arrived. Nabila stated, “We have trouble reaching the physician at the time we need to see the doctor. The only way to overcome this is through going to the emergency department.” Many women expressed the same concern of being scheduled in a timeframe when their complaint could be addressed but had to wait weeks to months to be seen and often had to wait for others to arrange the appointment. Johara stated, “The person suffers from pain and may even die before he can make it to the appointment.”

Women also recalled experiences of excessive waiting once they had arrived at the clinic. For Howa, the long wait led to anger. She described her experience,

I hate to wait though, especially when they let me wait inside the exam room. This may be for an hour or so. Sometimes I leave the appointment angrily. Supposedly when you schedule an appointment the doctor should be available to see you. That’s the point of scheduling an appointment. It’s not meant to go and wait. I’m going to the physician and I’m supposed to have an appointment. We don’t schedule an appointment to wait.

Likewise, Miriam and Fatima both recall times when they have had to wait over an hour to be seen. Miriam tells how she was left to wait and she was sure that she was forgotten. In anger, she left. She surmised, “Someone should at least be coming in to tell you she [the physician] is behind schedule... always the waiting time is very long and the doctor

time is very short.” Other women noted two ironies in waiting; one was for a serious condition in the emergency department, the other for the long wait for a scheduled appointment to arrive and then once in the clinic, to wait again for a long time to be seen.

Fatima explained,

You wait too long to get the physician, and then he is running behind... and then when you are late and sometimes five minutes because you had a problem, they will not fit you in. But the physicians are running behind like 20 or 30 minutes and that is fine. It makes me crazy!

The provider may also be out of reach for other reasons. Kareema had been told to contact her doctor even without an appointment if she had problems following eye surgery. She explained, “I visited the clinic three times but they are unable to reach him because he is on vacation.”

Even though some women were in direct contact with their provider and attempted to draw the provider’s attention to their need, they perceived that their requests were not heard. Nafeeza reported a story where she surmised that the treatment for her friend could have been simplified if only her friend had been heard. She explained that her friend had not followed orders to refrain from eating postsurgery, hence she experienced severe abdominal pain and visited the emergency department. She stated,

If they [physicians] had just listened to us and given her something to sooth her stomach, she would’ve been fine. A person is more aware about himself than anyone else and it is better for physicians to listen to their patients and to give them the medicine that they seek.

Jamila had a broken foot and told about her inability to be heard when she attempted to direct medical personnel to X-ray the side on her foot that hurt. Although she tried to tell the radiology technician that her pain was in a different location than the ordered X-ray, the technician explained that she had to follow the orders. Later the physician realized

this mistake and repeated the X-ray on the correct part of her foot and found the fracture. She added, “I’m more aware about the location of my pain and she has to call the physician and to tell him that the pain is from the other side.” In these two cases, the women reported that initially they were not heard despite voicing their concerns.

Unsteady Crossing

Frustrations about waiting often result because of expectations. Women as individuals with a variety of backgrounds and experiences differ in their expectations. The unfamiliarity of the U.S. health encounter can create uncertainty. This is particularly evident when participants faced the unnerving barriers presented by insurance and payment for health services. For many participants, the journey became unsteady by unexpected aspects to accessing and receiving care. A prime example occurs when access to medical care abruptly ends with Medicaid termination at 8 months after arrival to the U.S. Like faulty footing on a swaying bridge, uncertainty and fear prevail when the door is shut to health access and likewise on their hopes for receiving expert medical care. The full extent of each woman’s expectations before coming to the U.S. is not known but it is possible that expectations may have been set high. One husband explained that his infertile wife had seen many physicians in her journey to the U.S. In Turkey she was refused treatment and was told, “America is the mother of all treatment.” He explained that this renewed her with excitement and hope.

Expectations and behaviors within the visit are socially and culturally defined and emerge out of previous experiences. Iraqi women’s expectations are contrasted with those found in U.S. health encounters, leaving them to negotiate the conflict that arises from

unmet expectations. Overwhelmingly, women expressed that the basic expectation for their health visit was to receive a correct diagnosis and treatment for their health problem. Nonetheless, from an individual and systems perspective, the details of the health visit often differs significantly between the U.S. and Iraqi contexts. Conflicting expectations in the health visit or of the health system can be a source of frustration. Participants highlighted the differences between their expectations and what they experienced. The theme, ‘unsteady crossing’ depicts the identified problems that participants encountered when their expectations were in conflict with the health encounter experience. These problems included access to care, constraints within the encounter, use of questions and type of medical treatment received by Iraqi participants. Comments about medical treatment included both its effectiveness and perceptions of its affective components. First, brief background of the Iraqi health encounter will provide a context for some of the differences women encountered in U.S. health visits.

Women as well as key informants explained the general system of seeking both primary care and specialized care in the Iraqi health system. In Iraq, women recalled that when making a health visit, they were usually accompanied by a relative or friend. For primary care, women arrive at a public hospital clinic and are seen in the order that they come in for a minimal fee. They expect to wait an hour or less to be seen. Once with the physician, they can address any number of issues that concern them. The visit has no time limits. Patients can request tests to be ordered from their physician. In the community, medications are available in pharmacies without a prescription and it is not uncommon to purchase medicines for treatment on the basis of self-knowledge or the pharmacist’s recommendations. The U.S. health system stands in stark contrast to this, as will be

highlighted in the discussion below.

Maintaining a Perilous Balance with Missing Planks

System barriers such as lack of insurance or the need for copays are significant and apparently an unchangeable part of the health system. A market-based health system provides a precarious if not perilous balance for low-income patients to access care. Losing Medicaid at 8 months after arrival to the U.S. and continued life without coverage presented a frightful and unsteady state for many of the participants that were unexpected. Many of their comments alluded to the economic dangers inherent in illness. Several women identified cost and lack of insurance as barriers to getting the care they needed. The cost of paying for a visit is prohibitive for many of them, especially in the early years of resettlement when family members are not only adjusting to a new environment but also trying to find work. This is especially evident when family resources are scarce and Medicaid coverage ends. They usually opt to go without health care. Hannan explains, "...one fears future problems; the cost of health care is a problem. We are refugees. They should care about our feelings. We are new here and they should treat us differently." Khadija expresses the contrast in expectations from previous health care experiences, "In Iraq if someone had emergency pain or something we could visit any doctor and he would prescribe us medicines. For those who don't have Medicaid it will be a big financial problem." Other women explained that they have attempted to get insurance in order to get care but that it is unavailable or unaffordable and this puts the provider and needed treatment out of their reach. Johara explained her situation when her Medicaid ran out, "There are medications that I have to take otherwise I will behave like

an animal. Without treatment, I feel so worried and impulsive. And since treatment is so expensive, John (a case worker) bought it for me; he paid out of his personal money.”

The lack of health access is an unexpected problem that induces fear.

Unexpectedly Gagged

Once engaged in the health encounter, constraints were imposed by the limited number of health issues that could be addressed. Several participants found this restriction of expression due to time limits to be an unwelcomed surprise. Fatima, who worked as an interpreter, explained how she would try to prepare Iraqi women for this difference.

I think it was hard for us to understand in the beginning but these are the rules in the United States, that you have a certain amount of time and you can talk only about one complaint. So before we went to the physician, I told my patients, ‘please, we have to take care of one thing, the major thing. Because they only have a certain time and they will not be able to take care of many things at the same time so this is a rule.

She recalls patients asking her “Why are the doctors in a hurry? I want to talk.” And she would tell them “They don’t have time for you.” Hassana recalled this restriction of limiting complaints in her health encounter and stated, “When I complain of several things, the doctor will tell me that she will take care of two things in this visit and will address the other in the coming visits.”

In Iraq, women were accustomed to sharing all of their complaints with the physician at a primary health care visit and find rationale for listing all of their concerns.

As Nafeeza explained,

Usually people from the Middle East they used to tell the doctor all the issues, not only about their leg. One time I went for a headache and it hurt because I have a disc in my neck but she [physician] says, ‘we can only talk about your headache’

but I know it is related to my neck.

Issues of insurance, payment, and communication presented a difficult challenge for Iraqi women who were used to affording medical treatment and having the time to discuss their problems with their health providers. All of these factors likely added to the unsteady state of resettlement.

Uneasy Footing

In the U S. at a health visit, it is customary to review a patient's full medical, social, and family history at the beginning of each visit. Additionally, electronic medical records contain a template for reviewing body systems and this is part of the information required for billing purposes. The health encounter is often systematized with set questions that may be reviewed at every visit. In this context, template questions act as a foundation or footing for the visit despite the fact that several of the questions may not relate to the patient's current medical problem. Uneasy footing on this bridge may be a result of many factors at this point. Time is spent in building the provider's foundation for the visit with multiple questions while the woman has been told she must limit the number of health concerns that can be addressed in the visit. Additionally, these questions can include very personal information that Iraqi women may not freely speak about nor even mention between family members. Therefore, the questions may be perceived in any number of ways: as a culturally inappropriate topic of conversation or as an unrelated topic in regards to the reason for the visit or as invasive when questions are of a sexual nature. Several women commented on their experiences with these questions. Nafeeza explained that many questions are asked in the visit and some do not pertain to

her health issue and can be embarrassing if a family member is present. She was asked about her period and speculated, “because they want to know if you are pregnant or not. And some medications might affect the baby and I think that’s why they do it, I don’t know, maybe not.” She didn’t mind answering the questions but said, “...with my Dad being there, it’s not so good because I wouldn’t normally talk to him about that.” Naama explains a visit where she was translating for her mother, “The nurse was asking her [mom] questions and some of the questions were so embarrassing; ones you wouldn’t ask your mom, you know? She was asking me personal questions of my mom and then I am going to have to translate.” In one of the first visits to the clinic, Hasana noticed her husband became irritated in answering some questions. She explained, “I asked him ‘What are those questions?’ He told me that I don’t need to know them. There are questions that may be acceptable by the American culture, but can be irritating or provocative to us.”

Some women also found it repetitive and sometimes annoying that routine questions were reviewed every visit. Nabila explained her experience,

They inquire about everything, about our medicines, and our illnesses. It is a nice thing though they are repeating the same questions over and over in each visit... supposedly the physician should be able to review it and hence he doesn’t have to ask these questions over and over in each visit.

Sarah added, “They ask many questions and I hate that.” Sometimes the questions were asked twice in the same visit. Fatima reported that initially, the medical assistant asks questions and records them in the computer then “the doctor comes in and she keeps asking the same questions.” She surmised, “Maybe they [doctors] were too lazy to read. In reflecting on the many questions, Jamila expressed, “It is not necessary, why?” She explained that some of it is related to health issues and added, “...but you know some of

them don't know anything about your country.”

For one woman, the health visit interaction with a medical assistant included questions that were extremely invasive. In the context of what would be a routine medical intake, Ibtisam reported, “She [medical assistant] asked me annoying questions outside the normal medical questions. She told me if I'm not feeling comfortable here in the United States why did I come here in the first place. She was like interrogating me.” Ibtisam explained that because of this encounter, she left the visit and did not complete it.

The provider who did not ask a lot of questions was equated with being understanding. Naama explained,

A good doctor is one that understands you don't have to explain a lot to them... they understand where you come from and they know what you are talking about and don't keep asking a lot of questions, stupid questions....they understand without having to ask so many questions.

Likewise, when the provider did not have to ask a lot of questions, some women had a sense of being understood. Howa explained, “The good thing here is that when we visit the gynecologist, she will have all the information about us, like our past illnesses and our medications. Hence she will be better able to understand us as she already has preliminary information about us.” Huda said, “You don't have to explain [yourself] and that is why we would prefer to go to a Muslim doctor.” Understanding and being understood is complex and is partially explained in how women perceived and experienced treatment in the health encounter.

A Successful Crossing?

This section reveals how women felt they were treated affectively as well as effectively with the health encounter. Sarah expressed how the medical treatment conveys care, “Their [health providers] treatment has made us believe that they are good people. Their treatment, their physical exam, their questions, and their answers, for us, are all signs of care.” Women participants were asked about their perception of the medical treatment they received. Many of the participants reported that they had good treatment because they had relief of their symptoms while others found that the treatment was not effective. Those that related instances where treatment failed attributed the failure to various reasons. The medicine was often the cause of failed treatment. Johara explained that some women requested the same medicine that they brought with them from Jordan or Iraq, but didn’t get it, “...the brand is different and the result isn’t as good as the medicine they brought, it has a different result so they change doctors or they change the medicine.” Howa, who expected improvement after taking medication for a month, concluded, “...the other problem here, is that the medicines are not as effective as the medicines in Baghdad. That is why I might prefer not to see the doctor and let nature take care of my illness.”

Treatment in regards to medication use was often commented on by participants. Perceptions about the type or quantity of medications and reasons for using it were evaluated as part of the care they received. Nur explained, “They [health providers] like prescribing medicines ...they prescribe medicine for every single problem.” In contrast, Sarah stated, “In general, there is care and they [health providers] pay attention, but sometimes I found doctors not willing to give medicines unless there is extreme

necessity.”

Perceptions of patient and provider role emerged when discussing treatment at the visit. Nabila explained these roles,

Back in Iraq it is not necessary to do a blood test every visit unless I ask for that. For instance, if I ask the doctor that I want to check my blood to know the level of my sugar then he will do it for me. If I didn't ask, the doctor will not order such a blood test.

Nabila also gave her impression of the provider's role and explained the contrast between the treatment she received in the U.S. and in Iraq,

Some problems that I was suffering from have gotten better and some have not. In the last time the internist prescribed me medicines based on [my] history without even doing the physical exam. In Iraq, doctors are smart; they rely on the physical exam to understand what is wrong with their patient. It is not the computer that guides them. Here they give us treatment and they told us, 'let's try it and if it doesn't work, we will switch it.' Are we a field for experiments? We have been hearing that the medicine in the United States is advanced. Sometimes the treatment however works.

Khadija reported an incident where her requested medications for her high blood pressure were refused by the physician but later corrected. She explained, “When my Medicaid coverage ended, she [health provider] sent a letter explaining her apology that she didn't give me blood pressure medicines when I had high blood pressure. This is how things work in life; you may encounter a good or a bad physician.”

Some women expressed opinions about how they should be treated based on their own knowledge. When some women's treatment received in the U.S. did not match their previous experience, sometimes the conclusion was made that treatment was incorrect. Jamila recounted a story where she was uncertain about the physician's method of treatment of her broken her foot. She got a removable brace instead of an expected plaster cast. She explained, “Then they told me it is up to me if I want to cast it or not. There is

no such physician who says that. The bone needs to be immobilized so it will heal. The pain has never gone away because they didn't cast it."

Howa's perception is unique in that she attributed her failed treatment to her own health, "I'm receiving the correct treatment, but because of my deteriorated health and mental status the treatment is not working." She adds, "If a person is sick and the treatment is not helping him, it is not the doctor's fault."

The affective or emotional components of treatment include patient-provider interaction and the verbal as well as nonverbal cues that communicate respect, care, and concern for the patient. Overall, women recalled instances that were positive in regards to how they were received in the health encounter. One of the most positive responses came from Miriam, "They [health providers] are so welcoming; they listen to the patients with a smile to the point that patients don't feel like patients anymore." She continued to say, "They are treating me the same way as all other patients." Sarah stated, "There is reciprocal love and respect. They come in and shake hands with me with a smiling face." Hannan described her providers as, "kind and respectful... they are good in that particular context." Women also described the affective component of treatment in terms of feeling comfort psychologically (*murtaha nefsian*). Miriam explained this concept, "I believe that patient's treatment is largely psychological and I'm psychologically comfortable with them [providers]." This expression was also used by Nabila when she expressed her preference for a female physician, "psychologically I feel more comfortable." Naama admits that being a refugee may increase this need, "We are refugees and we are in a foreign country and we are in need of psychological comfort... especially when we go to visit the doctor."

In contrast, Hansana explained, “They [health providers] don’t have the ability to listen; they don’t listen to you in a way that makes you feel comfortable.” Nur related a story of her high hopes of finding effective treatment for her infertility but was told treatment would be very expensive and she would have a high chance of failure as she explained, “[the gynecologist] said that it was better to sit at home. She broke my heart and adversely affected my psychological status.” Office personnel also were noticed for their nonverbal behavior. Nabila contrasts her provider with one person she encountered at the reception desk,

Doctors respect their patient. Some people may not show respect. Perhaps this is because I am a Muslim woman or because I’m a refugee. I don’t know myself. I see such people do their job but without ever expressing any sign of welcome like smiling or so.

Treatment was viewed both positively and negatively by Iraqi participants.

Discussion of the treatment Iraqi female patients received revealed expression of various expectations they had of the health provider.

Repairing and Reinforcing the Bridge

The final theme reveals actions of repair, reinforcement, and evaluation the health encounter as perceived by Iraqi women. This theme depicts women’s agency in the health encounter to declare their identity, assert their preferences, and evaluate the cultural knowledge and adaptations of health providers. Participants speak of how they view themselves and their cultural values and how they took initiatives to maintain these in the health encounter. They also viewed health personnel’s actions through their cultural lens and evaluated how those on the other side of the bridge approached them or made adaptations (repairs) to the bridge to facilitate the health encounter. Women’s identity is

grounded in cultural values that intersect with gender and religion. From this foundation, they reveal their strengths and supports and how these were negotiated to make the health encounter functional. The hijab (scarf) marks them as Muslim and plays a particular role within the health visit that sometimes helped others to recognize their preferences. From participants' perspective, health providers were evaluated on their cultural knowledge and consequent adaptability to adjust the visit to meet the participant's needs in the health encounter.

Strengthening the Cables

Family members play a major role in supporting several aspects of the health encounter and function as supportive cables on the suspension bridge analogy. Women who had limited English proficiency relied heavily on family members capable of making appointments, interpretation at the visit, and transportation. When asked about any difficulties she had scheduling an appointment, getting transportation, or finding interpretation at the appointment, Howa explained, "It is so easy, my daughter does all of that for me." Family members are often, called upon to fill in when the interpreter is unavailable; often this is in an emergency situation. Johara explained, "One of my children will translate or if it's necessary [at the health visit] then they will call for an interpreter." Women found some relief in addressing these challenges by themselves or with the help of their family, thus relying less on the interpreter. As Fatima explained, "The interpreter was late so I started doing it [health visits] myself because I can speak [English], I can manage the situation so we just take care of ourselves... we did everything ourselves." English proficiency was the key to managing for one's self. Sarah

explained, “I think my situation could be different from others because I can speak English and I can manage myself so I didn’t have the problems that other Iraqis face.” Family members were preferred as interpreters for some women. Ibtisaam explained, “Initially my husband interpreted for me, but later on, I was relying on my daughters, before I start to depend on myself. Sometimes, my daughters are at school, and my husband is at his work, and so I have to rely on myself.” As discussed earlier, gender difference is also an issue, making some family members poor choices as interpreters. Huda explained, “It is not appropriate that my son does the interpretation.”

It is usual for women to be accompanied by a family member at a health visit. Family members can provide a hand to hold or a supportive presence in the challenging situations presented by the health encounter. Their welcomed presence may possibly have a positive effect on an individual’s health. Hannan is a young adult who said, “I go to visits with my Mom. It is better if someone else is with you.” Family members may provide a significant amount of emotional support for individual women and hence, family’s absence can be a source of worry and fear. Hasana explained that she had been treated for severe depression and when asked what would help her cope, she said, “Even if you worry and are unable to sleep, being in the middle of your family, brothers, and sisters will make you comfortable so that you would’ve forgotten the illness.” She had spent a short time in the hospital for treatment of depression and found that being away from her children was very difficult and discomforting, and added to her worries. She said, “As long as they [children] are in my sight, I’m comfortable. I will accept the illness, the fact that I can’t sleep and the fact that I talk to myself doesn’t matter as long as they are near to me.”

Howa described the impact of her extended family's absence, "We are far from our family. This constitutes a fear and a deep sorrow." Nur explained that being far away from her extended family "hurts deep inside."

Hasana recalled a clinic waiting room experience where she was supported by others once when she was very ill and tired. She had no appointment, but her husband brought her anyway to be seen. He explained, "While we were waiting there was an American patient who gave up her turn for my wife when she found her so tired. I won't be able to forget her favor; she forfeited her appointment for my wife." At the same visit he recalls that there was no interpreter but, "There was a Sudani patient and she volunteered to do the interpretation."

Fortifying Identity to Reinforce the Bridge

Identity and cultural orientation within the health encounter may not be the most prominent issues that health providers consider when interacting with patients. Yet from the patient perspective, maintaining values within the health encounter may be a formidable and necessary struggle tied to their identity and cultural values. This section reveals how Iraqi participants expressed and gave meaning to identity, fortified their identity, and maintained values. Interactions surrounding the health encounter reveal participants' creative agency to maintain identity and values while achieving their goals. At the same time, the reactions of others to their appearance provides insight into others' knowledge and assumptions; this creates another layer of complexity between people where communication, gender, and religion (culture) intersect.

Women expressed themselves in terms of their identity and how this identity was

experienced in the health visit. The hijab (headscarf) reveals outwardly that they are Muslim and carries with it various underlying assumptions for Iraqi woman, health providers, and clinic staff. In order to understand how women participants gave meaning to wearing the hijab, I included women's various reasons for wearing the hijab. The idea of choice and freedom to choose denies the common notion of being coerced into wearing it. Several women explained their personal decision to wear it and the varied meanings behind this article of clothing. Wearing the hijab is the point where they are identified by others as being Muslim. Miriam explained, "That's how they differentiate us, and without the hijab they think nothing." Women participants expressed various reasons for making the decision to wear it and nearly all made it clear that it was a free choice within the context of religion and culture with statements like, "it's part of the religion," "our traditions imply it is forbidden for us not to wear it; God will hold us accountable if we didn't wear it," "it's a religious thing," "we are Muslims and we wear hijab; there is no critique of it," "it is part of Muslim's identity," "it is mostly because of culture but for me it was fully my choice," "I have the freedom to be the person that I like to be and wearing it is what I want; nobody forced me to wear hijab," "I was free in choosing to wear hijab and I'm comfortable with this choice," "If it wasn't my choice, then I wouldn't be wearing it," and "I feel as if the hijab is protecting me, so that nobody looks at me and bad thoughts cross his mind. It is protecting everything beautiful in me."

None of the participants felt the hijab created any negative reaction from providers within the health visit, but several participants identified the hijab as a point of discussion and discrimination in public settings. Miriam explained, "Because I am covered it was hard to find a job and all people look at you like you are strange." She

recalled feeling fearful riding public transportation when pregnant and explained, “I was using a bus, believe me, to get to my [appointments] and I was pregnant and I was getting there by myself. I am pregnant, I am Muslim I was wearing the hijab. So it could be [the hijab]. I was scared from everybody people stare.”

Women recalled several instances where they identified themselves as Muslim and explained how they experienced this in the health encounter. Nabila expressed an assumption that others should know that wearing the hijab implies certain behavior and rules including gender-concordant care. She explained that a male interpreter was arranged for her physical therapy appointment and stated, “I can’t expose my legs in front of a male interpreter even if he was Iraqi. I’m a woman who is wearing hijab.” Howa explained how she is identified by wearing the hijab within the health encounter and stated, “We visit the doctor and we are wearing the hijab so they know that we are Muslims and that we fast.”

Several women encountered experiences with providers and medical office staff in regards to their dress and identity. The interaction with others in the health visit reveals knowledge and assumptions based on the participants outward appearances. Fatima recalls being misidentified when she was wearing black, “I remember only once when a medical assistant asked me about my religion. I was wearing black coat (*abaya*) and black hijab. She thought that I’m a nun.” Johara explained, “...some of them will say, ‘you are wearing hijab because you are Muslim, right?’ And they know you have to cover your body and your hair. ‘You fast for Ramadan, right?’ They will tell me like that... they know, but they want to make sure.”

At her health visits, Khadija also noted, “They usually ask me where I am from but not my religion. Like when they see me wearing, [hijab] they will know. Or maybe

they will just make sure by asking.” When Ibtisaam was asked if her provider knew she was a Muslim, she replied, “Yes she knows that as I am wearing the hijab.” Miriam noted, “I told the lady that I needed to make an appointment and she saw me wearing hijab she asked me if I need a female doctor. So she knows that already.” Despite these distinctions, women overwhelmingly felt that they were not treated differently than other patients by their providers because of wearing the hijab. Sarah explained, “They [providers] are people who respect their profession and there is no such discrimination.”

When interacting with male health providers, several women explained how they took initiatives to adapt to the health visit and maintain their values through preparing for the visit and voicing their preferences to guide the actions of the provider in the visit. Two commonly problematic areas with male providers were mentioned as responding to a handshake and being disrobed for an exam. Naama described how she prepared for the medical visit and stated, “I make sure not to wear thick clothes.” This was done so that the male provider could easily listen on top of her clothes with the stethoscope. Howa said, “Sometimes they ask you ... can we go under [your clothes]? ‘No you can do it on top of my clothes.’ Or [if] they want to do blood pressure they can do it on top of my clothes.” Another problematic area for some women was being offered a hand shake from a male provider. Howa explained that when offered a handshake from a male provider, she would say, “No, I don’t want to shake your hand.” She noticed the provider’s reaction and commented, “Then the whole time you are there they are afraid of saying something or doing something.”

Seeing to the Other Side

Evaluation is required before repairs can be made. Women participants were asked more specifically about their health care experiences in order to understand the importance of being identified (by religion or nationality or culture) by their health provider, what they expected health providers to know about Islamic practices, and what characteristics a provider exhibited that facilitated or disrupted their health encounters. Asserting or guiding their preferences often left participants with destabilizing experiences and some unexpected repercussions, much like a loose plank on a bridge. When health providers or other staff applied their knowledge and were culturally responsive to the participants, these were analogous to others laying down more stable planks for firmer footing in order to help the patient to meet the provider and thus facilitate the encounter. Women recalled what health providers should know and what they actually knew about Islamic customs. Participants also evaluated provider knowledge and accommodation to their care and revealed the characteristics of a good provider.

Several participants evaluated provider knowledge and accommodation to Islamic customs within the health encounter. Two main areas where Islamic customs intersected with health care were Ramadan, and gender-congruent care. Gender-congruency was tied to issues of modesty and exposure in an exam and offering and receiving handshakes, both of which present no barriers if the provider is female. As mentioned above, participants overwhelmingly voiced that a female provider was preferred for reasons of being understood and feeling comfortable with communication. Several women felt it was helpful if the provider was aware of some customs like Ramadan, when it is

customary to fast during daylight hours for the month. In this month, medication timing and diet changes may need to be arranged. Ibtisaam acknowledged that her provider knows she is Muslim and that she fasts and she took steps to direct her care, stating, “I visited the doctor while I was fasting so I told him that I can’t take the medicines at the usual times.” Nafeeza felt providers need to know more and adjust and said, “If that doctor knew how important Ramadan was he would never say like oh like you have to take it. He would have said, ‘okay I will give you a different option’ maybe, I don’t know.” Johara differentiated what a provider should know according to the type of health visit. She listed areas where providers need to have cultural awareness as “contraception or if you are pregnant or talking about sex and Ramadan because of the medicines.” She also mentioned gender-congruency for the physical exam and stated, “is not against the religion, a female for a female; a male for a male.” Huda felt that providers should know more about their customs signaled by the fact that they are covered. She recalled, “Like if you want to shake their hands you would go first but then if you don’t want to and you don’t want to embarrass them and have that awkward moment then they should know that not everyone shakes hands.”

The place of religion and cultural traditions in the lives of Iraqi participants cannot be underestimated as these are integral parts of identity and daily life. When asked if their health provider should be aware of their identity (religion, nationality, and cultural practices), opinions varied widely. Some women felt that the health provider should stick to medicine, “A doctor should be dealing with a human regardless of their religion.” Others felt that providers do not need to know the details, just the basics as it relates to medical need like fasting and insulin medication, while others felt it depended on the type

of visit. Khadija stated, “I think they [doctors] should ask and try to be aware of what a person needs culture-wise because you would want treatment to go well, to help the patient and not give them another dilemma.” Fatima welcomed the interest of provider’s inquiries about Islam and stated, “It is nice that some physicians know about our religion and culture. She (physician) knows about Ramadan and what we can eat... I feel comfortable visiting her. She understands me.” Naama was never asked about her religion in the visit and surmised, “They don’t ask about religion. I suppose that there are certain regulations or instructions that prohibit asking about religion. We would love to be asked about our religion.”

Women participants expressed varied opinions about what providers actually know about Islamic customs such as Ramadan. Some were uncertain about how much detail their providers knew and opinions varied about how important this was. Several women acknowledged that providers know the basics but not the details. For example, they know about Ramadan but not when it occurs. In regards to provider knowledge of customs, Ibtisaam noted, “There is progress but I wouldn’t say they know a lot.” And Nabila conferred, “They know the basic things but not the details.”

Despite provider’s apparent lack of detailed knowledge, women related instances of health provider accommodations that helped facilitate the encounter. Several women told how they had informed the provider of the month of Ramadan and the provider accommodated to these changes. Huda explained, “In Ramadan, she was giving me medicine that I can take once at night and once before I start my fasting. She knows about me and she does not discriminate that I’m an Iraqi Muslim.” Miriam explained when she was going to surgery, “I asked them not to remove my hijab and they respected that.” In

the midst of her disappointment at having a male provider when she had requested a female, Huda noted, “He was like so respectful and he said, ‘If you don’t want to do the exam today its okay, don’t worry; it’s their problem not yours.’”

Several women also explained the characteristics of an effective provider. Communication was characterized by understanding, nonverbal acts of care, and appropriate vocabulary. Nabila explained,

It’s the way they communicate. They show care and not just like they are just talking and they give you these big words that you can’t understand ...[they] actually speak to you and like in English not in medical...they show they care like maybe eye contact, I don’t know, or appropriate touch.

Care was also related to a sense of provider’s display of effort to solve health issues. Miriam said, “You want them to try you know? ... and I don’t expect them to solve everything but trying is the thing.” In citing qualities of a good provider, women expressed, “She listens to me.” “She is not in a hurry; she understands what I am going through.” “...respects you, listens to you and treats you well,” and “They try to advise in the right way; they respond to the patient.” It was also important that the provider took time to advise and to direct as Miriam surmised, “she was like these cool doctors that know what she is doing and you trust them.”

Several providers were described as understanding and 4 women connected an understanding provider with the fact the provider was not from the U.S. Howa said, “He was also a foreigner....and he understood our situation so he was really very good with us. He was very nice and he knew what we wanted.” Miriam commented about her provider, “She was good and kind; very understanding. She was Iranian.” Nur described her relationship with her provider,

Like my doctor is very friendly and we were joking and talking about many

things, yea, she is not American. I think she is from Argentina. And always she pushes me, she says be patient. She always advised me, be patient because you will find a good thing here. She is a very good one; she understands what it means if you move from a different country.

Providers who understand, connect, and show empathy are the ones that received high ratings. This fits the idea of being comfortable psychologically. Actions that communicate empathy and understanding begin to dissolve existing differences.

Discussion of Iraqi Participant Data

As patients, Iraqi Muslim women with refugee backgrounds are in an unfamiliar environment of constant negotiation. When entering the health encounter, they attempt to successfully communicate their health concerns to the health provider in the midst of an unfamiliar culture in order to get the treatment they are seeking. Their expectations are embedded in the context of Iraqi health visits. Very little of this historical context transfers to their present health encounters in the U.S. health system. So they struggle in making their way into and through the system. The analogy of the suspension bridge fits the predicament of the patient who is located at one end of bridge and needs to make it to the other end of the bridge in order to meet the provider and be treated.

The Bridge under Construction

From the participant's view, the bridge is situated across a foreign chasm that is difficult to visualize fully in one glance. The bridge rests at each end of a chasm that is formidable, deep, complex, perplexing, and frightening. In this analogy, the chasm represents the health system. The bridge depicts the actions, support, help, and decisions needed by the patient in order to cross over the chasm. This is a well-traveled bridge in

clinics that serve a wide variety of refugees and immigrants. Nonetheless, it is characterized for these travelers by its missing planks, high winds that rattle the traveler, and wide views of the threatening environment in the chasm below. The patient's goal is to reach the provider by crossing the bridge. The provider is situated at a designated clinic on the other end of the bridge. The distance between patient and provider points to existing differences that either thwart the visit or invite patient or provider adaptations to make crossing feasible. It is important to note that health providers may feel obligated to meet the patient and venture toward the patient by making cultural accommodations, yet these are limited and rest in the will of the provider.

In the following discussion, I endeavored to highlight how the colonial nature of the health system maneuvers power, subjugation, knowledge, and representation. Within this discussion, the various perceptions and experiences of Iraqi participants will be drawn upon to answer the research questions.

Barriers to Building a Stable Bridge

A Colonial Setting

Both provider and patient are confined to the bridge that is established in the formidable chasm. The analogy of this bridge can be viewed as colonial because of its set structure, its placement across a forbidding deep chasm, and the lack of alternative means for crossing the chasm. On the provider's side, the bridge is of stone and anchored solidly on the side of the chasm. It has been firmly placed there by the dominant Western society that has dictated the clinic location, clinical structure, and the method of rendering medical services. It has been designed and established that the provider's side is the only

location for treatment and because of this fact, those on the other side are obligated to make their way across the bridge to meet with a health provider in order to be treated. Providers are established on one side (in a clinic) and are not expected to cross the bridge to provide assistance. The bridge transitions across the chasm and becomes a rickety suspension bridge that will have to make due and function for the Iraqi women who are crossing it. The health system operates in one selective language and espouses a defined set of customs and behaviors, with little room for any other option. The setting as such is unfamiliar to an Iraqi Muslim woman. In some ways, it may rattle her expectations of a health visit that she acquired from her previous experiences in Iraq. Both the unfamiliarity and the set structure of the bridge demand her conformity to the set structure. This demand can leave her perplexed, annoyed, and dependent on others. It is in an established health system that is difficult if not reluctant to accommodate to individual need or difference. The system dictates that she must cross, but there is little provision for assistance, which sets her up to great struggle and potential failure.

Power and Subjugation

Communication barriers produce subjugation in several ways for Iraqi Muslim refugee women. The bridge creates an environment that marginalizes and subjugates those who do not speak English. All capacities of communication in the system are carried out in English from scheduling an appointment to receiving treatment. Signage in the clinics is nearly all in English with only a few signs in Spanish. For many Iraqi patients, the environment has no familiar symbol or sign of their linguistic roots, undoubtedly reinforcing patient perceptions and experiences as an outsider. The system's

absorption in English-only language at each level of the encounter limits women with limited English proficiency from fully engaging in the system and the health encounter. Despite the efforts of refugee agencies to supply interpreters, Iraqi women often find communication a barrier and desire to be independent in communication as well as fully understood. Women are subjugated by being dependent on the interpreter and the refugee agency for arranging the appointment, transportation, interpretation, and time management in order for the health encounter to occur. As women have experienced, the interpreter has to be a skilled negotiator within the system and dance between system and provider time limits while using a variety of skills. Multiple interpreter roles that are often thwarted by time and transportation issues can cause bouncing of the bridge, which is counterproductive to steady walking. The role of the interpreter is destabilizing when appointments do not fit into a time slot, the interpreter is not on time, or when providers and interpreters schedules are not synchronized. On the occasions when interpreters can make the necessary steps required by the system, women advance across the bridge and find the trusted interpreter a valuable resource and support on a bridge that has missing planks and blowing winds.

On the bridge, wind and distance can also depict other differences that interfere with communication. The woman is not heard due to the distances created by differences in language, and not being heard within the encounter. Not only have many Iraqi women been unable to communicate with their provider when needed outside of the health encounter, but also within the encounter, they have not had their concerns heard despite efforts to direct the provider's attention toward them.

Cross winds can make the passage across the bridge treacherous. Both cross

winds and distance block cries for help and a woman can remain stranded on the bridge without her voice being heard. For example, in most cases, the need for gender-concordance in both the provider and interpreter is a necessity for the woman in order for the encounter to be fruitful. Women's voiced concerns and requests are stifled when concordant gender care is requested and denied. Some felt powerless to change the circumstances of having a male provider and subjected themselves to an exam by a male provider rather than wait hours for a female provider. Additionally, several women indicated in gender-nonconcordant care they are suppressed in their expressions, feel less comfortable, and hence are understood less than with gender-concordant care.

Time issues are also like wind that makes the bridge sway, causing some uncertainty and conflict in expectations. Visits are scheduled long in advance, and health needs are often either treated by self-medication, emergency visits, or they resolve by the time the appointment arrives. The clinical structure denies time for expression within the visit and limits the patient in presenting only two areas of concern. Having limitations to what can be treated in the visit is a new concept and these unexpected parts of the system are like strong winds producing unexpected struggles to accessing and receiving treatment. The onus is then on the patient to put forth effort into new attempts to cross the bridge by making more health visits.

The suspension bridge with the deep chasm below is threatening for anyone who attempts to cross. Patients are in an unfamiliar environment with a need to cross the bridge to meet the provider for treatment. On the bridge, patients are in a situation of powerlessness due to the structure of the system, which includes functioning in the system's language, time limitations, and dependency on others to help schedule, interpret,

and guide the visit.

Women express powerlessness and subjugation within the health encounter. Many Iraqi women participants related experiences where they were caught off guard or irritated by questions asked routinely in the health encounter. As an Iraqi woman struggles to hold on in cross winds and keep an eye on loose planks, she finds a bridge unexpectedly swaying by events in the encounter that remind her of her precarious position as an outsider. Questions used as provider footing in the health encounter originate from the dominant culture and reflect norms as topics of discussion. But for an Iraqi woman, these questions are perceived much differently. The questions can be perceived as invasive because they run counter to her values and norms of what should be discussed openly. It is not only about the personal or sexual nature of the questions but the company in which they are shared and the appropriateness of the questions to the reason for the health encounter. Some women also mentioned the annoying repetitive nature of the questions. These questions are like a loose plank flying and hitting her in the face, sometimes causing a cultural sting, or insult because they contain content that is unmentionable in conversation. Other questions are painful due to the company in the visit, or are simply annoying by the nature of their repetition. The nature of the questions asserts the dominant cultural stance and negates any other position or understanding of her cultural perspective; such is the context of subjugation. Routine use of the template questions denoted lack of provider understanding for some women.

Knowledge in Negotiating a Crossing

Experiences of both physical and affective treatment revealed how some women perceived treatment in the health encounter. Sometimes a woman's knowledge that she firmly held about herself and her medical condition was disregarded and sometimes it was not heard. At other times, a woman's knowledge based on past experiences did not match the situation she faced and she was left confused or frustrated. Several women recalled instances of treatment that differed from their expectations. Expectations that were in conflict with past referenced experiences were like faulty planks on the bridge producing some doubt, surprise, and annoyance.

Women's expectations became evident when recalling experiences with obtaining medications. Providers did not supply medications in the quantity or quality that was expected. Some providers admitted to difficulty in diagnosing and prescribed medications by trial, which raised doubts as several participants felt providers should have answers and be confident in how they treat. It is possible that physicians have been socialized in providing patient-centered care that includes patient decision-making about treatment and full disclosure of treatment. Patient choice and decision-making may be unfamiliar for Iraqi women. By soliciting their choice for their own treatment, providers may have been viewed as uncertain or incompetent and thus may have raised doubts about their competency in patients' minds. This view agrees with Braman and Gomez (2004) who questioned the validity of patient participation in decision-making as it may be interpreted as the provider's inability to make treatment decisions. Physicians in particular are highly regarded in Iraq and failing to remain within the constructs of this high esteem may jolt a patient's expectations, raise doubts about the quality of care, or

not be understood. In addition, it is possible that this view will prevent the finger pointing at the provider for a failed treatment. Patients can often be in a physical or mental state of powerlessness because of illness. Howa's picture of powerlessness included her admission that her medications failed because of her mental state rather than because of her provider.

Providers hold the power to diagnose and treat. Pilnick and Dingwall (2011) have suggested that there may be a natural asymmetry in the provider-patient relationship that is expected and is not necessarily a barrier when the patient actively defers to the provider to obtain the common goal of an accurate diagnosis. Patients as receivers of this service are often put in a powerless position unless the provider has the ability to hear the patient's perspective and concede that the patient has knowledge. Either not being heard or being disregarded for her knowledge will add to the sense of subjugation and powerlessness.

Building a Stronger Bridge

Providers have power to influence the treatment and the encounter through affective or emotional components of care. Affective components of care are like voices that come from the depths of the chasm either encouraging or discouraging the woman who is crossing on the bridge. Some women expressed their hopes pinned on a provider that could supply the needed treatment or words of encouragement. When this was not realized, they were affected psychologically or in their soul. Several women expressed an increased need to be psychologically comfortable especially as someone with a refugee background. Health clinic staff also had an impact for 1 woman who expressed receiving

little respect and no engagement from staff and concluded that she received this probably because of being seen as a refugee or a Muslim woman.

Affective or emotional care is also related to the numerous ways in which Iraqi Muslim refugee women were regarded and identified outwardly and how they identified themselves inwardly. They self-identified as Muslim and different than the surrounding culture by wearing the hijab. When the hijab indicates female identity as Muslim, it creates an avenue of religious regard. This regard included both self-identification and identification as 'Muslim' by office staff and providers. The label of 'Muslim' has vast variations and assumptions that can be a source of conflicting information and confusion. It was apparent from the Iraqi women participants' perspective that providers identified the hijab with being Muslim and that included treatment adjustments such as with medications during the month of Ramadan and consideration of possible issues of modesty, and gender-concordant care. Women identified themselves primarily by being Muslim. Identification by nationality was secondary to this and identity by race as Arab was not mentioned. It is likely that lines of race/ethnicity, religion, class, and nationality are blurred for providers with the label of 'Muslim' being the predominant identification because of the outward dress and implications in medical treatment adjustments that are linked with known religious practices.

Identification solely as Muslim is limiting. As Joshi (2006) pointed out, it may mistakenly include all people who resemble Arab Muslims and may reduce an Iraqi woman's identity to one static category that discounts the unique meaning of race, religion, and gender for the individual woman. He noted that Iraqi women are particularly vulnerable to intersection because of the outward identification of the hijab.

Intersectionality fuses unique categories such as religion, race, gender, nationality, and language into one category (Brah & Phoenix, 2004) and this can conceptually congeal by the appearance of the hijab. This may leave the provider with a small set of assumptions in the category of 'Muslim' that exclude the unique and various meanings and interpretations of being Muslim for individual women as well as discount the other aspects of her identity (race/ethnicity, language, education, class, nationality) by fusing them into this one category of 'Muslim.' From this perspective, multiple forms of oppression can potentially emerge (Hancock, 2007).

I find it significant that one woman surmised that there was a rule that religion could not be mentioned in the encounter connecting this possibility to the rule of not mentioning religion in the schools. The absence of religion as a formal patient identifier or as a point of inquiry or conversation in the health encounter may be attributed to multiple reasons. Despite the historical roots of Anglo-Saxon Protestant establishment of aspects of society today (Kim, 2004), personal identification with a formal religion is waning rapidly in the U.S. (Pew Center for Research, 2012). In addition, the clinic is usually seen as an institution without religious affiliation (Laird et al., 2007a) as was the case for each clinic these women visited. Providers may avoid asking about religious affiliation or discussing spiritual or religious matters due to its apparent lack of relevance to treatment, lack of training in its potential relevance or approach, or personal apprehension about religion (Sulmasy, 2006). In line with intersectionality, providers may confuse race and religion and have poorly defined concepts of Muslim and Arab and therefore may be unaware of the role that religion plays in the patient's life and deny the possibility that religious discrimination exists (Sheikh, 2007). Religion may be

categorized in the broader idea of the patient's culture. Though it may not directly influence medical treatment, the mention of religion as culture may downplay the centrality of religion for patients who identify themselves solidly within their religious identity. In this context, the lack of inquiry or conversation about religion, especially when it is welcomed by some patients, can lead to religious disregard and poorer affective care or inferior patient-provider relations. However, patient-centered care creates a challenge for providers as they attempt to focus on what is important to the patient, engage the patient as an individual, and balance patient-provider cultural differences so that differences are not minimized or overemphasized (Teal & Street, 2009). Despite various differences between provider and patient, provider behavior and expression of empathy or validation are some of the most important aspects for the patient in the health encounter (Batakis, Frank, & Epstein, 2009). This finding was substantiated in this study. Several women spoke of the limited view of provider knowledge of Islam but more women seemed to conclude that provider knowledge of Islam was less important than actually understanding and connecting with the woman herself.

Most of the Iraqi women participants strongly voiced their opinion about wearing the hijab as freedom and choice as much as obligation, comfort, and identity. When asked about wearing the hijab, they actively represent themselves and aligned their identity with stated values espoused in Islam, thus indicating their distinctiveness. The general tone expressed was self-asserting as to defy the stereotype of the suppressed woman as portrayed by the U.S. media. The current trend to wear the hijab speaks of a psychological and social dimension where women sense peace and centeredness by

publically aligning themselves with Islam as well as creating a sense of community (Ahmed, 1992). As Leila Ahmed (2011) pointed out, there may be many meanings for wearing the hijab, including its meaning as a rejection of the West. Ahmed has also identified the current trend toward wearing the hijab as a point of solidarity and as a “dress of a minority” (p. 210); it is a visible sign to the dominant majority that this dissenting group are asserting their traditions and ideals and taking a stand against the racial and religious backlash in mainstream society.

Additionally, a woman’s identity as Muslim was often tied to assertions of the strength and importance of family and others who provide supportive presence. In a Western context where the individual is paramount, the idea of family decision-making and family cohesion may be unfamiliar. Space for family involvement at visits was not a problem mentioned by Iraqi participants at primary health encounters. Family and supportive presence was significant for health and mental well-being while their absence can be a source of distress. When family members are not available, the interpreter seems to fill in as a support person. As they cross an unfamiliar bridge, the significance of being accompanied by a supportive, known, and culturally congruent person highlights the importance of this component in the health encounter.

Signs of Repairing the Bridge

Several participants expressed ways in which they attempted to equalize their position in the encounter or become empowered such as dressing in light clothes for the exam so there was no need to be undressed. They requested gender-concordant providers and interpreters. Their requests to maintain cultural values were not always met and they

took the initiative at times to leave the visit until a later time when conditions could be met. When requests were heeded or even anticipated prior to asking and accommodations were made, it was like helping hands assisting them to cross the unfamiliar bridge.

Women were not reluctant to explain what constituted a good provider. Providers that made an effort to connect in some way with patients seemed to replace rickety planks for solid ones so that women could more easily cross the bridge and reach the other side for the encounter. This was like helping her arrive at the encounter in a less exhausted state so that the meeting between patient and provider could be not only effective but comforting. Providers who showed empathy, and interest in the culture, language, and the patient's meaningful events were the ones that bridged the distance created by difference and make a human connection. Several foreign-born providers were identified by women as the ones who understood the rough journey of transition to this new culture. It is likely that common connections like these will facilitate the encounter. This was also found in a study of 214 patients (Street et al., 2008); when they perceived similarities in personal beliefs, values, and communication with the provider, the relationship was strengthened.

Engaging in an effective health encounter between patient and provider is a complex task for anyone. Individual Iraqi Muslim women have highlighted the complexity of the health encounter by sharing their perceptions and experiences. The intersection of difference (race/ethnicity, language, gender, religion, culture) emphasizes the critical nature and complexity of communication. Women's experiences highlighted how the health system and some providers retain power and knowledge in the health encounter and thus subjugated women. While participants as patients were disempowered in multiple ways, they were also empowered by providers and others in the clinic who

acknowledged them in validating ways like communicating empathy and understanding and accommodating to their needs. The women were also empowered by their own actions as if repairing the loose planks as they crossed this unfamiliar bridge. They made progress across the bridge by their efforts in asserting their identity, and in making accommodations to maintain their values and beliefs in the midst of a seemingly unrelenting journey. The experiences shared by the participants give fresh insight into the dynamics of human relations within the confines of the health system and health encounter. Many of the issues raised apply to all health encounters and therefore reflect on the efficacy and humanity of the present health system.

CHAPTER V

HEALTH PROVIDER FINDINGS

This chapter presents the descriptions of the health encounter from the perspective and experiences of 10 health providers. They included 9 physicians and 1 physician's assistant from 5 clinics serving a significant number of refugees. They are all primary health care providers and, for the sake of brevity, will be referred to as providers. My specific aim is to describe providers' individual perceptions of Iraqi Muslim women as patients and how their interactions shape the health encounter experience. Secondly, I will address the intersection of differences (race, gender, religion, language) perceived by the individual health provider with Iraqi women as patients. I use a postcolonial lens in my analysis and interpretation to uncover relational concepts within the patient-provider interaction such as power, knowledge, representation, and subjugation. My findings are based on an analysis of interviews and observational data in clinics, as well as my own experience as a health provider. Pseudonyms are given for each individual.

In this analysis, it became meaningful to continue with the previous analogy of a suspension bridge. The provider sits at one end of the bridge and the patient attempts to cross in order to meet the provider. Themes for this chapter will be from the provider's perspective of the bridge. It is important to note that there are many people crossing the bridge and groups of refugees are identified because all of the provider participants

worked in clinics that served refugee groups. There are times when the provider accommodates to the patient in order to assist the crossing in some small way.

Themes

From the analysis of provider interview data, four themes emerged and include the issues of health care encounter barriers, provider and patient differences that affect the encounter, how the patient is represented in the provider's view, provider accommodations to patient differences, and suggested changes to improve the encounter. The theme 'falling through the gaps' reveals the multiple barriers that patients face that stem from the clinic system and provider-patient communication. The subthemes include (a) starting late and falling through, (b) slippery cables of communication, (c) squeezed by time, and (d) I see she is burdened. The second theme, 'there are strangers on the bridge,' encompasses how providers perceive the culture and identity of Iraqi female patients and includes the following subthemes: (a) I see her on the bridge, (b) compared identity and fused vision, and (c) recognized but unknown. The third theme, 'measuring the bridge's gaps and planks in the fog,' reveals provider's assessment of what makes the encounter functional and what is missing from both patient and provider perspectives. From this provider perspective, three subthemes emerged: (a) approaching the gaps, (b) inspecting the gaps in the fog, and (c) adjusting the planks. The final theme, 'repairs to the bridge,' speaks to the way in which providers envisioned change to improve the encounter for themselves and Iraqi Muslim female patients. The three subthemes include (a) replacing the cables of communication, (b) reorienting the planks, and (c) restructuring the other end of the bridge.

Falling Through the Gaps

Providers identified multiple intersecting barriers around and in the health visit that were referred to as gaps and associated with the idea of patients falling through or falling out. I easily recognized the analogy of patients falling through the gaps in the bridge. Falling through or falling away is inevitable when bridge cables are slippery and planks are missing. The first theme includes identified barriers in patient-provider interaction or the health system that prevented effective interaction. The topics most commonly identified as barriers were communication, patient access to care and providers, time for the visit, and past patient trauma. Providers were quick to point out that language differences had far-reaching consequences that impacted the patient's ability to access care, navigate the health system (insurance, copays, scheduling), arrange transportation, understand treatment, and be understood by the provider. Time constraints were an added barrier to the visit that was compounded by communication issues such as the need for interpretation. In the health encounter, the squeeze of time is analogous to the narrowness of the suspension bridge where patient or provider is likely to have trouble addressing health issues due to time constraints and the quality of the visit falls through the cracks. The burden of patient past trauma was seen as a barrier to helping the patient and this too was accentuated by a difference in provider-patient language. Providers recognized the load of mental and emotional burden carried by patients and acknowledged how it inhibited their ability to cross the bridge and engage effectively with the provider.

Starting Late and Falling Through

Providers noted that the patient's lack of English proficiency intersected with multiple barriers such as scheduling, insurance, and connecting with the provider. Many providers commented that patient access to care was tenuous and based on their ability to navigate the complex medical system. Ann notes problems in communication starting at patient check in, "There are a lot of communication issues obviously and you know appointments that fall through." The difficulty in getting approved for Medicaid was seen as having an impact on their health due to a late start with care. One example was explained by Kathy,

There are a lot of times they are getting into care later because of the Medicaid card change. They are not getting vitamins on board until way later because they didn't have the copay that is required, so people [pregnant patients] are starting behind the 8 ball in terms of anemia.

Pam's explanation of patients falling away fits this analogy as she described Medicaid's time limits,

They are constantly worried about their Medicaid running out and it is hard for them to re-establish care (when it runs out) and the ones I have are new and I presume at some point they will fall away because the Medicaid will run out.

Several providers found that patients were aware of the time limit on Medicaid for refugees. Some providers felt that this knowledge caused Iraqi patients to unload excessive complaints, increased the number of visits to address complaints and made referrals difficult to accomplish in a timely manner. In contrast, Jessica found that more frequent visits facilitated her understanding of the patient who had multiple complaints, that were difficult to address and said, "Being able to check in frequently is better than trying to see someone every 6 months. And then it is also easier for me to navigate." Pam described the challenges of insurance time limits for Iraqi women and stated at the first

health encounter, “you try to cram in as much as you can but these folks need more than just primary care.” And about referrals to specialists, she added, “Then getting them the secondary care within that little window of time if they are insured and getting them the specialist they need is an incredible challenge.” Other providers pointed out that some insurance fails to cover the needed referrals and that this was also a point for patient frustration.

Slippery Cables of Communication

Communication barriers were expressed in various ways and noted by providers to affect many aspects of patient care that included limiting the provider’s ability to understand and treat the patient. Providers described many types of communication barriers, their link with cultural understanding, and the consequences these had on the health care encounter. Several providers explained the barrier in terms of the patient’s lack of English proficiency and linked this to the quality of care that the patient received. Poor communication and barriers to effective communication were like slippery cables on the suspension bridge that offered no grip for patient or provider.

The barrier to direct verbal contact with the provider outside of the clinic was a repeated concern. Ben explained this problem,

Language is a biggy. And then I think because of language having the kind of access like everyone else who can just call and say ‘I don’t get this [or] what do I do with this medicine’ or the message has to go through other people and I worry they will be sick and they will go to the ER instead of calling here first.

Sarah also mentioned that communication barriers result in emergency department visits and alluded to the lack of system resources as a contributor to communication barriers.

She explained,

Obviously many of my non-English speaking patients may not even understand that there is a way to contact me after hours. And even if they could it is unlikely that I could get a three-way interpreter line, so there is no after-hours access.

Jeff also found communication to be a system barrier. In reference to effectively addressing communication issues, he remarked, “We don’t have any logistical support for cultural bridges.”

Communication became an even larger barrier after patients had been referred to a specialist and returned to their primary provider. Several providers related instances of communication problems where patients and primary providers were clueless as to the care received at the referral or of any subsequent plans of care. This was attributed not only to the patient’s lack of English proficiency but also to interprovider communication. Primary providers were frustrated and concluded that the patient was unable to understand treatment or to communicate any details of their referred treatment. Sarah explained the situation when the patient returned to her for care, “She [patient] didn’t even know which medicines she was taking. But like you know... that is a huge barrier for me, how am I supposed to care for her?”

Use of interpreters was also a barrier to direct communication with the provider for several reasons. In the health encounter, interpreters were often late or did not show up. Jeff explained that this is a common problem with responsibility resting on the person scheduling the patient and “that falls through the cracks all the time.” Several providers had positive experiences using a phone or computer system where an interpreter was verbally accessed from another location. One provider mentioned that several of her Iraqi female patients preferred it over the interpreter’s physical presence because it assured privacy and modesty. Some providers had the equipment but did not feel proficient using

it or had to bring it from another room to use it.

Accounts of poor interpretation were numerous and stemmed from various causes. Often interpreters were not trained and of poor quality. Providers recalled interpretation where the patient may have been left out of the conversation and where they have also felt left out of the conversation between interpreter and patient. Providers also acknowledged the limitations and lack of appropriateness when interpretation was delivered by family members or male interpreters. While some providers wondered about an Iraqi woman's freedom to speak in the presence of a male, Ann asserted, "The woman will not be able to say what she wants when the husband acts as interpreter." Like most providers, Karen saw issues with the quality and gender of interpreters, "We don't have people who are great objective translators; males can't translate sensitive issues that are taboo to discuss." Sarah observed that sometimes a male interpreter is assigned to the visit and she noted, "Some get it and some don't. So [for the exam] I have to prompt the interpreter to look away or leave the room" in order to preserve the patient's modesty. She went on to explain that she can get through the exam without the interpreter present. Some providers mentioned that they would not use a male interpreter and would reschedule the visit out of sensitivity to the perceived need for the woman's modesty.

Interpreters were assessed on their ability to connect the provider with the patient and the success of the encounter was often accredited to interpreter's communication skills. The language barrier was interpreter-dependent as assessed by Jeff, "Barriers all depend on how good the interpreter is. If they are motivated or not can be a barrier." He adds that familiarity and respect facilitate the visit, "And if you have a translator that is known and knows you and the patient then the respect is already there and the cultural

gap is at least easier to navigate.”

Language barriers had several repercussions on the visit for both patient and provider. For Ben, language difference between patient and provider was seen as a barrier to getting to know the patient. He explained,

I don't think we get to know them as well on as personal of a level. That's anytime when dealing with a person from another culture you have a hard time getting the humor or understanding the social life as well.

From Donna's perspective, the patient's lack of English proficiency had many repercussions for the patient. Donna was not alone in surmising that this led to more tests. She explained,

I think that people who don't speak English tend to have more tests and blood work and studies and procedures simply because sometimes we don't communicate as well and so we order more to try and solve the problem rather than working from what is on the history. I think in the end it translates into a higher cost of care.

Provider's acknowledged that communication was not just about words but also about understanding that stemmed from the patient's cultural perspective of health and medicine that differed from the type of medicine practiced in the U.S. The differences were assumed to be large based on some accounts of patient compliance and follow through. Most examples focused on communication problems about medicines that may have been linked with a cultural understanding of the medicine's purpose and length of use. Jeff explained his perception of what needed to be communicated regarding medications. He stated, “You gotta keep things simple and um and make sure they understand the concepts and that medicines are not miraculous and some medicines need to be taken for long, long periods of time.” Jessica found it difficult to explain the use of medicines to a few of her Iraqi patients and stated, “I don't know why I can't get the

point across about medications. They don't understand that you have to keep taking it.

What is it? Like the pill thing is lost on them.” Ben described the different cultural perspective some patients may have about medicines and he makes it a point of communication. He stated,

I've learned to ask about their home pharmacy. A lot have medicines from Iraq because they would rather have that freedom of access to them instead of having to get it from [us]. Like you can buy valium over the counter and they consider that a really mild medicine whereas I get really worried that they are staying on it for years.

Kelly also realized Iraqi patients had other sources of medicines and said, “And then a lot of people get medicine sent from home to them. And they will be like taking something and I will have no idea like... it's not even a formulation we even make here.” Other providers described situations where they attempted to explain medications or prescribed treatments, but realized later that the patient did not continue with the treatment. Jessica felt communication could be part of the reason, but also included other possibilities. She said,

I took it either as I am not explaining well, I haven't made myself clear in how they need to hear it or they are not seeing the results they want, or they have seen the results and are cured.

Although opinions varied among providers, communication barriers were identified as the most salient reasons for the probability of diminished quality of care. Communication in the end had to do with the patient's inability rather than the provider's ability to bridge the barriers in language differences. Those who emphasized patient teaching and communication were concerned about the patient's level of understanding. Kelly explained,

In terms of the education you know with each visit I get worried that it's definitely sub-par. Because I will say, 'do you have any questions?' And they will

say, 'no.' And so, do I just sit here and spout off (laughs) you know about stuff? I try to explain every test I do.

She also reflected on how the barrier affects her own interaction in the visit. She said,

Language is a huge barrier because when you feel like they are not really getting it... you are going to say less, they are going to ask fewer questions. And so you don't always quite know like what is being understood and what is not.

Jeff felt the quality of care was related to both communication and cultural expectations that were patient-based limitations. He said,

I do think they receive a good quality of care. They receive as much as they can get in. They get good quality of care but access is limited by translation, transportation-logistics. My own personal bent [is] the standard of care is no different but counseling and explaining preventive care is lost in translation because of language but also because of their frame of reference; it is not something they are used to.

Donna seemed to agree with this position. When asked to assess the quality of care for an English speaker and a non-English speaker, she stated, "I think that the overall level of care... hard to say... I think it is equal as long as you understand as well as you can." But she concluded, "But I don't know if it is better or worse care. I think it is kind of a mystery as to what is really going on sometimes."

Sarah explained it as different care that stemmed from the patient's cultural context. In response to the probability of non-English speaking patients receiving a lower quality of care, she explained, "I don't think intentionally they would. They receive different care and often by their choice. I think they often desire to receive something similar that they had in their homeland." Kathy also alluded to the cultural element in communicating. She explained,

I would say it's more the cultural issues of trying to explain what it is they are really worried about and trying to make that clear for the doctor of why they are really there. Because if it takes several visits or if it is really vague um as a doctor I can do a lot of things that are not helpful at all and have the potential of giving

her a lot of side effects and lots of uncomfortable tests.

Squeezed by Time

Communication intersects with limited time and both work together to impact the health care encounter. The barriers of patient-provider time limitations are analogous to trying to cross a bridge but being squeezed and unable to move. If patient and provider are unable to move, the health encounter is at a standstill and may lack the focus it needs to address health concerns. The time squeeze is compounded by the extra time needed for interpretation and explanation of care. The multiple demands on limited time were as source of frustration for provider and patient alike. Some providers felt like they could not give what they felt was necessary care in the allotted time while others increased the frequency of visits to alleviate this. Additionally, a time-limited health encounter was linked with the possibility of suboptimal care.

In one clinic, refugee patients were given two time slots to allow for the extra time needed to discover and treat their problems. Ben explains that even this was not enough time because he had learned that it was important to know their story. He explained,

I would say it is a small minority of my patients that I have been able to take the time to do that, to listen to their story. In theory I know it is important but in reality when I know I have their five issues and limited time I don't get that [story].

Some providers felt the lack of time left them frustrated and mentioned that with Iraqi patients, more time was needed to “establish trust,” “establish a relationship,” “do more for them,” “help them understand,” and “be sensitive to their needs.”

Several other providers commented on the time it takes to use interpreters and to

explain the health system. Some noted more time was spent talking to the interpreter rather than explaining everything to the patient. Several providers felt that language difference and time constraints together may affect the quality of care. Kathy explained,

It takes time to have a conversation and when you use an interpreter it takes twice as long because everything is spoken twice. So just by time alone, we have the best intentions of being as thorough as we should be but I am sure it [quality] is compromised.

The combination of time limitations and the need for more time in the visit for interpretation resulted in providers running behind schedule. But Julie was quick to admit that patients needing interpreters “were not unique in that sense” and explained there were many reasons for running behind schedule.

Providers revealed that time constraints had other consequences related to Iraqi patients and the health system. The time squeeze for the encounter resulted in some providers adjusting the visit to focus on the main health problems and to avoid the details and/or on the multiple complaints that were characteristic of Iraqi patient visits. Jessica explains that the combination of many complaints and time limitations is very difficult and tiring.

It is really hard to take care of people that have multiple, multiple somatic complaints and I think that is a barrier for me and that is really frustrating you know when you are in our system in terms of barriers, we never have enough time.

Due to the additional time needed to see non-English speaking patients, Ben was cognizant of how he directed communication. He stated,

When someone doesn't speak your language, sometimes it is easy to give instructions and end the discussion without them having the opportunity to end the discussion. You're in a little bit of a power position. I say when I have a time that I have to finish and I just say 'okay here is what we are going to do and come back at this time.' Somebody who spoke your language might say 'but wait I also need to talk to you about this.' And sometimes you can just... that is something I

might feel a little guilty about is that I can just cut it off. And we spend the extra time but it's not enough. But it is a little easier to just have it ended and say 'okay we are done' and take a little more paternalistic approach. Maybe because of the language you get away with it a little more.

Several providers revealed the challenges they faced by the time limits imposed on them by the current clinic system. One provider pointed out that allowing only 15 minutes per patient fails to acknowledge that patients varied in their time needs. They also worked with the reality that patient time needs worked in opposition to statistical outcomes that measured revenue in terms of the number of patients seen. Kelly explained, "But for right now as it stands, the reimbursement is about how many patients you see." Ben was also mindful of the time-reimbursement issue with refugee patients where they get a double time slot in his clinic. He explained, "They [refugees] are Medicaid and I get paid half as much and they are taking twice as long (laughs). So as long as I am seeing enough other patients I can still get along with it." Some providers realized that the time limits were not ideal for accommodating to non-English-speaking patients' needs and this often left the patients frustrated. When reflecting on this, Kelly explained, "If you were truly doing a refugee health care clinic and that was the focus then I think you would schedule things very differently." Both Ann and Julie felt an hour for a visit would be ideal to answer questions and establish trust. Julie had worked in a clinic piloted to address refugee health needs and reflects on the hour long visits as a different kind of care that had time to develop trust and a bond with the patients, "So I feel like the care there was optimal because of the bond that was created. There was trust that came from that." Many providers may agree that the system with time limits interferes with the communication needs of both patient and provider.

I See She Is Burdened

Most of the providers acknowledged that Iraqi female patients were burdened by past trauma. From the provider's gaze on the bridge, some women's historical trauma was acknowledged yet unexplored at various levels. The burden was labeled as trauma or as post-traumatic distress disorder (PTSD) and was often explained in terms of psychosomatic symptoms. Although all provider participants delivered primary care, they varied in how they perceived their role in addressing mental health. Several providers mentioned referrals for counseling and in-patient treatment for Iraqi female patients. A few providers attempted medication treatment along with comanagement from mental health professionals while other providers avoided the attempt to treat and manage symptoms through medications. For some primary care providers, the patient's past trauma was seen as a barrier that was difficult to diagnose or understand. For others, it was something they did not feel the need to address for various reasons. Some providers acknowledged that communication and cultural understanding intersected with mental health issues that added a layer of complexity to the visit and as such, it was determined to be a barrier. In addition, the burden of mental health was its own barrier when providers became perplexed in searching for an effective treatment or when they were challenged in diagnosing and treating multiple psychosomatic symptoms that they linked with emotional trauma.

Three providers commented on their efforts to treat in conjunction with counseling resources. Prescribed medications for symptom treatment was not effective and they were often questioning the cause for this. Ben noted gender differences and explained that female Iraqi patients displayed more severe symptoms when compared to

their husbands who had been the recipients of torture. He commented, “So I wondered is this a cultural thing where guys have all the same symptoms but just don’t address them?” He also felt that there was a stigma attached to getting help and added, “I do see quite a few of them [men] going and seeking help but I see the women more willing to take the step and get help.”

Several providers mentioned the need to sort through multiple physical complaints and while deciding which ones needed to be immediately addressed, they also suspected some symptoms were related to a traumatic past and labeled as psychosomatic. Kelly found that Iraqi women carried an especially heavy burden of trauma that affected how she processed her thinking in the health encounter. She explained,

So to always be thinking of that trauma component and how that impacts their health... and so I have to walk this line between do you have to work up every single time the patient says they have chest pain or do I really think about... well, what was happening in your life at that moment?

Jessica found this exercise to be difficult as a new provider and stated, “It can be very frustrating seeing a patient who is saying, ‘I have back aches and my head aches every day’ and figuring out how to explore that and the connection with mental health issues.” Kathy also admitted her frustration with treating one patient’s mental health issues and questioned the issue from multiple angles. She admitted frustration in treating an Iraqi woman with severe PTSD who failed to take her medications. She surmised that this may be attributed to the patient’s mental status. She stated, “It’s all around psychiatric care. I mean it is depression and PTSD, and insomnia and all of that.” The patient failed to take her medications and symptoms persisted. Kathy tried different medications but symptoms persisted. She was sure to coordinate care and increase her understanding from those counseling Iraqi women but failed to see the patient make any progress. In the end, she

concluded,

I haven't figured out what I am missing. And it is not for a lack of trying. I don't understand all the psychological barriers and issues. I don't know if she is so profoundly depressed that she doesn't understand the medicines or if it is something cultural or... if she [the patient] keeps coming to have me fill out the Department of Workforce Services paperwork.

The paperwork was filled out on a regular basis to excuse the patient from work due to her severe depression. Not only had this one patient's mental health treatment acted as a barrier, but it created suspicion about its legitimacy because Kathy was beginning to see a similar trend with mental health complaints from a small group of Iraqi female patients and their request for the paperwork to be filled out to excuse them from work. She explained,

I feel like it is very patient dependent. I couldn't make a generalization. Although now that some of us have started talking it sounds like we have these patients that are all exactly the same. There is this group of them and I don't know if they are friends outside of this place and so they have formed the same somatic complaints. I'm not sure if it is something about participating in work or being capable of participating in society here.

Other providers had more of a distanced stance with mental health as a barrier but acknowledged its existence and expressed the probability that its origin rested in a traumatic past. Pam explained, "The pelvic pain I think is more somatic but it's not necessarily frustrating it's just disappointing and discouraging that we aren't making progress." Julie felt that mental health barriers were a tremendous challenge for the provider and patient alike because of differences in cultural expression and language. When referring to a patient with complex neurological symptoms that were mistakenly labeled as psychosomatic, she explained, "People had no idea what to make of it but could identify it as something legit but maybe hadn't been listened to because of the way it had been presented."

Most of the providers acknowledged that a mental health assessment was made somewhere along the patient's journey and assumed that trauma did exist somewhere in the past for Iraqi refugees. The majority of the providers did not directly assess or treat Iraqi patients for mental health problems for various reasons. Donna rationalized that mental health issues had been addressed by others beforehand. She explained,

Like if somebody is already getting help, I don't want to change what they are doing. I am not a psychiatrist. When they come to my clinic, they have already had a whole evaluation and they have a psychiatrist to help with any psychological trauma that could have happened to them before they came. So I try not to get messed up or mess with anything.

Sarah had heard many stories about the past trauma of her patients and others who had been referred to her for gynecological care had a diagnosis of PTSD in their charts. She surmised that probably a lot of women had some trauma or psychosomatic complaints when they saw her but she chose not to review it with them. Ann did not feel the need to review it because the issue did not pertain to the visit and discussing it may cause trauma to the patient.

In summary, providers recognized that patients struggled and often fell through the gaps primarily because of communication barriers. These barriers existed because of language differences, poor interpretive services, and time limitations. Consequently patients had trouble understanding and hence arranging transportation, insurance, and scheduling; they were also unable communicate and access the provider outside of clinic hours. Communication barriers were also proposed as a main component in understanding patient's past trauma. Many of these barriers could be hurdled if the patient knew English. The language gaps also affected providers as they functioned in the visit with limited understanding and often had to do more tests or see patients more

frequently to diagnose a health problem. They recognized language and culture as barriers and accommodated by attempting to explain their own limitations and that of medicines, making messages simple, and providing gender-concordant care and modesty when needed. Providers judged the quality of visits based on communication and acknowledged that communication gaps existed elsewhere in the system as did other reasons for running behind schedule.

There Are Strangers on the Bridge

This theme speaks to providers' recognition and conceptualization of culture, and perceptions of Iraqi and Islamic culture as expressed through their experiences with Iraqi female patients. Providers refer to their experiences and other sources of information in order to create a workable conceptualization of the Iraqi female patient. In the end, Iraqi female patients are recognized in terms of generalities such as appearance, language, religious practices, and common clinical presentation, but along with this, providers raise questions as to the deeper context of Iraqi identity, cultural practices, and women's perspectives. Providers recognize the Iraqi female patient but admit that this recognition is limited and there is much that is not known about her.

I See Her on the Bridge

This section addresses ways in which Iraqi Muslim patients were identified and represented in the health encounter. This is analogous to identifying an approaching person at a distance on a bridge by viewing their familiar walk, size, or shape. There is a recognizable element but it does not reveal her full identity. Providers shared numerous

generalizations about Iraqi female patients that were formulated from various sources. Generalizations also contained distinctive characteristics that appeared to be formed largely from repeated patient encounters.

When asked about identifying Iraqi Muslim female patients in the clinic, various characteristics were mentioned and several providers alluded to her style of dress and primarily by the hijab, although it was acknowledged that this was not always reliable. As Ann explained, “Sometimes you meet women who say they are Muslim and they don’t wear the scarf. That is the only thing I can think that might ever give you a heads up.” Providers also identified an Iraqi female patient by the medical record where notes were made about language preference, country of origin, or refugee agency contact. Race or ethnicity was not mentioned as an identifier. Sarah said that she identified the patient “when she doesn’t speak perfect American English.” She then gathers a history of her origin and journey to the U.S.

Most providers indicated that religion was not part of the patient inquiry but that it was assumed by outward appearance, the patient’s connection with a refugee agency, the fact they were from Iraq, or by having an Arabic interpreter. Kelly explained how she identified Iraqi patients as Muslim,

I don’t ask them usually. But it usually comes out. They will often tell me they don’t want a male and that usually means they are Muslim. And I will ask, is it because of your religion, are you Muslim? Sometimes their dress will lead me to believe they are Muslim. I don’t ask unless it matters.

Many providers were uncertain if there was a place for recording religious preference in the electronic medical record. Only one provider noted asking and recording a patient’s religion. Providers described a general perception of Iraqi Muslim women formed by a repeated set of characteristics observed in health visits. Many providers mentioned that

Iraqi patients, including women, had high expectations about the health visit, the provider's role, the system, and treatment. Statements were sometimes linked to a proposed explanation or justification for this trait. Jeff stated, "They have high expectations of the system to fix them." Ben also mentioned Iraqi patient's high expectations and explained why he thought this was common for them, "This group of people seems used to being able to get their health care needs met pretty quickly. And they are used to quick access to specialists." He adds to the possible reasons for these high expectations, including Iraqis rather high educational level and being aware of a short time frame to getting health needs addressed. He also alludes to the political context for Iraqi patients and stated,

Some of them have said it straight out to me that they feel a little bit owed or a lot owed by our government to take care of them and to take care of these problems because they don't feel like the problems were their doing.

Pam felt that the expectations were grounded in the patient's view of medicine and the physician's role. She explained,

I think there is sort of this sense that medicine can solve all of these issues or that there is sort of one blanket cure for these problems or that there is something that you as a provider can do to make everything better. I think that is one of the hardest things is that we can't fix everything and some of these problems are going to be chronic or...there is also a very strong sense that the medical provider can deal with your employment situation and your housing situation.

The characteristic of high expectations was tied to the number of complaints presented at a visit. These were mentioned as "5,000 complaints," "a laundry list," and "10 problems they want taken care of right away." Amy felt that patients became frustrated when these could not be addressed in one visit and stated,

They are pissed if you don't address everything. And I will say, 'I can't do that today. I can't talk about that today. I have spent 30 minutes about the fact that you can't sleep, that you are depressed and you have back pain. I can't also address

your knee pain, your allergies, your and oh by the way your ... I can't do all of that.' So in that sense, I feel their expectations are somewhat unrealistic.

Iraqi patients were also characterized by their desire to have multiple medical tests. Julie attributed requests for specialized tests to a woman's high educational level, or "hearing a little bit of information from her friends," or the context of the health care environment in Iraq. She related a patient request,

Sometimes there can be a real push from the patient to do more and more diagnostic tests and I tend to really explain why that is not appropriate. I have a 30-something-year-old Iraqi woman I take care of now and has back pain and like she is really wanting an MRI and she does not need an MRI. And it is this battle every time we get together as to why she doesn't need the MRI.

Ben also characterized them as wanting many medical tests and he characterized this as "more demanding" due to the urgency and time limitations they sensed in getting their needs taken care of. He explained the challenge.

You know I have had really good relationships with them and things have gone well but I have also had some encounters where they are really frustrated with me for not getting them into a specialist fast enough, not referring them right away.

Sarah agreed with this perception but then qualified it as human nature. She stated, "So I think there is like a desire. I don't know if there is a desire or just a perceived desire for tests and medicines and a fast result. And that's human nature though, that's not Iraqi. That's human nature."

Several providers also mentioned that Iraqi women had respect for physicians. Ann was informed of this by an Iraqi female physician friend. Ben was informed by an Iraqi patient that stated, "Back home we view doctors as close to God." Three providers tied this trait with a common Iraqi patient need of being told what to do by the physician rather than being involved in their treatment through decision-making. This in turn affected the consent process. Sarah explained,

Well I do find in this population that they are very respectful of physicians and they aren't as comfortable with the informed consent process. I think with Iraqi women, I think they are very used to the doctor telling them what to do and that they may not be as comfortable if they are given options about elective procedures.

Providers identified Iraqi Muslim female patients by outward dress, language, and sometimes, national origin as well as their seemingly common traits expressed in the health encounter. Despite the label 'Muslim,' religious expression was identified as a cultural trait, which was predominant over nationality, language, and race/ethnicity. Providers also used this conceptualized identity to compare and contrast Iraqi Muslim female patients with other patients with refugee backgrounds.

Fused Vision and Compared Identity

When inquiring specifically about Iraqi patients, providers often gave general responses about Muslim patients. Many admitted that they were uncertain if they were explaining an attribute that belonged to an Iraqi patient or a Somali or an Afghani woman. The fused conceptualization of Iraqi women with other groups resulted in mistaken or undetermined identity. As Iraqi women were viewed, they were also differentiated by comparison with other groups of refugees. This is the provider's view from their distant clinic on one side of the bridge where they are situated. Vision is limited and a full grasp of the Iraqi woman's identity is unclear and therefore undetermined.

Providers in this study all worked in clinics where a variety of refugees were seen for care. It appears that providers used comparisons to distinguish Iraqi patients from other refugees who frequented the provider's clinical experience. Comparison comments

were not solicited but freely offered by the participant in response to a variety of questions.

Comparisons between Iraqi patients and other refugee patients were made in reference to varied clinical and social aspects. Iraqi patients were most frequently noted for their higher educational level, and their ability to quickly get a driver's license. Amy felt her impression might be attributed to the selection of patients she sees and stated, "The [Iraqi] women are so smart compared to other cultures like Somalis. Or maybe it is education and not nationality difference." Ben also noted their educational level and how it compared to others in the encounter. He questioned, "I don't know if they are more educated than other refugees so they just assert themselves more." In reference to explaining a gynecological exam to patients, Pam stated, "Iraqi women are educated compared to other refugees and Nepali patients have no clue of this exam." Julie connected their educational level to the patient history in the exam and stated, "Iraqi women are savvy and know their [medical] histories better than Africans." Pam realized that the vision from the clinical encounter may be skewed by a "slice" of people that present as patients but she also gave a general comparison of Iraqi patients with Somali. She explained,

So I think it is interesting as refugees, you see different slices of people come from different countries. Um... Somalis you see the least educated and the poorest of the poor. That's a slice. The Iraqis were frequently folks on the higher echelon who were educated, who were wealthier. So I think that was a very different slice of the population than we were exposed to.

Iraqi women were compared to others when it came to provider's approach to the interaction in the health visit. Jeff shared, "They [Iraqi patients] are not like the Bhutanese who are more differential. They are not like that where they just expect you to

tell them what they are to do. They [Iraqi] seem a little more comfortable with the style I am used to as an American.” Kathy compared her approach to Iraqi women with others in her experience and stated, “I think of my different approach with Iraqi women. I probably came in more formally initially and eased into a more comfortable interaction whereas many of the other African cultures, Burundi for example, if you come on immediately in a warm and personal way you are going to make that personal relationship immediate.” She also compared Iraqi and Burundi women by the distance between patient and provider in the visit. About the visit Julie stated, “I would say that Afghanis and Iraqis are the ones that will take longer. Whereas a Bhutanese or Burmese patient, I am going to have to like beg them to give me more information.”

A few providers compared Iraqis to other refugees by the level or type of suffering and consequent symptoms. Donna was uncertain about Iraqi trauma but compared it to other patients. She explained,

But a lot of them [Iraqis] have experienced a lot of trauma and that is why they decided to come out here ... a lot of loss. And whether it was you know like my Africans where they were being chased by machetes and things um ... I don't see that from Iraq but a lot of them have been hurt or killed.

In reference to comparing Iraqi patients to others she had seen, Amy stated, “They are more traumatized than other Muslims.”

Iraqi patients were primarily identified by being Muslim or by their nationality. A few providers told stories where patient nationality but also race/ethnicity and language differences were fused into one as both patients were identified as Muslim. Kelly related a lengthy story of a Somali patient who had refused birth control explaining it was Allah's will and how she felt this had a negative impact on the woman's health. In the middle of the story, she admits, “That hasn't happened with Iraqi women, I apologize that

I am extrapolating to other cultures.” She continued with the story and explained her struggle in reconciling issues with the Somali patient and family then compared Iraqi women and said, “That is not the way of communication with Iraqi women, they are very respectful of medicine.” Jessica grouped Iraqi women and all Muslim women together and stated, “Um I think what is also interesting for Iraqi women and Muslim women in general is that they are a different patient with their spouse there.” Pam seems to initially fuse her idea of Iranian and Iraqi women in the health encounter and said, “Sometimes the Iraqis are princesses but more often it is the Iranians. They are Persian princesses sometimes. They are very entitled. Actually that can happen with any culture but for some reason that Persian princess comes to mind.” She later finds a distinction between groups and added, “It’s not all of them. Most are humble, beautiful people. I really enjoy working with the Iraqi more than the Iranian I would have to say.”

Recognized but Unknown

In this subtheme, providers shared both their knowledge and questions about Islam, Muslims, and cultural practices. Specifically, they spoke about how they experienced various Iraqi women’s expression of religio-cultural practices and values in the health encounter. These topics focus on gender issues, Ramadan, and male family members at the visit. Providers recognized and acknowledged these practices as part of Iraqi Muslim female patients’ identity and explained how these cultural issues influenced their medical management and their perspectives. Participant providers also cited the sources of their knowledge and reflected on the role the media may have played in their conceptualization of Muslims. Many questions about practices, values, and beliefs of

Iraqi Muslim female patients and their families and communities were proposed by providers and these were identified as unknowns. From the providers' perspectives, Iraqi women were recognized but remained relatively unknown. Ann set the stage for this provider perspective as she recalled her approach in addressing a Muslim patient's preferences during Ramadan. She explained,

'I know it is Ramadan and I know some people don't want their blood drawn is that okay for you?' I think that really helps the physician-patient relationship. I'm saying like 'I understand some part of you. I don't understand all of you... you are not all familiar to me but... I recognize this part of you though.'

Providers raised many questions that revealed various types of unknowns about Iraqi women, Islam, and cultural perspectives. Some providers related their struggles in attempting to understanding a vastly different set of values presented by Iraqi Muslim women. When Iraqi Muslim female patients are recognized yet also unknown, it is like the provider's view from the bridge. The provider is at a considerable distance from the patient so that the Iraqi woman is recognized and identified as Iraqi and Muslim but when stopping to consider her in more detail, vision is not so clear and many questions remain.

Most providers indicated that their perceptions and knowledge of Muslims and Islam came primarily from their experiences and encounters with patients. Others mentioned obtaining a general idea of Islamic traditions and values from a close friend, Somali medical assistants, interpreters, an Iraqi shopkeeper, and the internet. Two providers found it helpful for their understanding of cultures to have lived outside of the U.S. for an extended time in or near a predominantly Muslim country. When providers were asked about the influence of the media in their perception of Muslims, many immediately referred to the events of September 11, 2001 as a media event that produced a negative impression of Muslims. Two providers entertained the idea that the media

might have influenced their view of Muslims; three adamantly denied that it did and others stopped to consider the idea, but remained uncertain about the influence of the media on their conceptualization of Muslims. The question of the media's influence triggered some participants to recall their ideas about Muslims and Iraqis. Many affirmed that their idea of Muslims came from individual encounters with patients. Sarah stated,

[Before] I didn't know any Muslims. My impression is that they were radical, they are war driven; they are terrorists. And taking care of people has totally changed my view. They are those people, those words, but they are also very peaceful loving people.

Similar to other participants, Jessica had not considered the idea of connecting the media with her idea of Muslims or Iraq. She explained,

The feeling I have about most of our Iraqi patients is that they are people who went out on a limb to help Americans in Iraq and sometimes with very devastating consequences for themselves. So if anything, I feel like these people put themselves on the line. And it is interesting. I have never made any connection between 9/11 and our patient population, although I know it exists.

Providers' awareness and knowledge of Islamic practices and traditions seemed to come largely through patient experiences. Providers recalled how Muslim practices interfaced with advice and adjustments to medical treatment of Iraqi women.

Overwhelmingly, responses focused on the adjustments that needed to be made during Ramadan, the month of total fasting during daylight hours. Most providers told of the need to change medication regimes, refrain from drawing blood for lab work, and to adjust insulin dosages. Some mentioned filling requests for birth control pills so that women would not bleed and therefore could pray during the important pilgrimage to Mecca.

When asked about knowledge of any Islamic practices that were harmful or beneficial to health, provider responses varied. Some providers paused to consider the

intersection of religion and health as a novel idea. Jeff stated, “I have no idea um... it’s never something I’ve been.... I don’t think it does. Because the decisions I have seen I don’t think have any religious bearing but that could be something I am entirely wrong about.” In contrast to this, several providers referred to their experiences with patients during Ramadan. Although some felt Ramadan was neither beneficial nor harmful, several related negative patient experiences to the month of fasting. One provider recalled a diabetic patient fainting from fasting. Amy stated, “But there is some current literature on that but... the reality of it is in some ways it is very unhealthy.” Several others had to think a while and one admitted that this was a novel question. She stated, I never really thought about that before.” And another admitted, “But I don’t think I am educated enough about all the Islamic practices that my patients are engaged in to know if they are beneficial or harmful.”

In considering other customs and Muslim female patients, providers recalled the importance of gender in the health encounter and connected it at times with the role of family members. All of the providers were very aware of the more obvious preference for a female providers and female interpreters because this was requested when patients scheduled the appointment and because, as female providers, they received many patient referrals from male colleagues.

Female providers were certain that their gender was a positive influence in the health encounter with Iraqi Muslim patients with comments like, “They are glad I am a woman,” and “My gender is an absolute bonus.” In reference to female Iraqi patients seeing her as a female provider, Julie explained, “I think it immediately set a bond; there was immediately something there. And that was great.” Donna felt it helped Iraqi patients

for her to be female and explained, “I actually think it helps them when doing a pap smear or a personal exam that I am a female and I have gone through it and know what it means to get these tests because it is quite an invasion of privacy and for many of them.” Julie spoke of comfort, “With a female patient [and the provider] being female there is immediately more comfort than if they had a male doctor asking questions or doing an exam.” Amy felt that her position as a female provider offered an important cultural connection. She explained,

Like I come in and kiss them on the cheek so there is some exchange, because that is culturally what you do. Thinking about how does that play out for a male physician... they are not going to do that with a male physician. Then that is missing some cultural connection.

Ann felt that a female provider was vitally important for Iraqi Muslim women so she made efforts to always refer to them to a female provider.

The 2 male provider participants mentioned referring Iraqi women to female providers for gynecological exams, but like their female counterparts, they also noticed that the issue of an Iraqi Muslim female patient seeing a male provider was not always clear cut. As Ben mentioned, “It varies, like who is comfortable with who[m]? It is okay for them to prefer a female doctor for female issues. American women have the same preference [and] both influenced by their own culture.” Jeff commented on the Iraqi female patient’s visit and her husband’s presence. He said,

We have to be attentive to the gender issues that come up specifically with female people and their religion. In terms of Iraqi women I see them typically in the presence of their husbands and have gotten to know them well enough that helps a bit too.

Female providers also shared various perspectives with having a male family member at an Iraqi woman’s health encounter. Pam was able to incorporate the male

family member into the encounter. She explained,

The male is kind of a guard so you feel like you kind of have to step back and give space until there is a level of trust there. And the direction of the interview goes to the male with the focus on the female but the male is there. That relationship has to be formed. Because that relationship between you and the male in the room doesn't get formed then you are not going to get access in my opinion.

Other providers also found that a woman's husband might facilitate the health encounter by encouraging the patient to take the provider's advice. There were several accounts of husbands showing genuine care toward the wife's health condition and for Julie this seemed to break a stereotype. She explained her experience,

I saw a lot of loving couples. And the majority of men that I saw who accompanied the women were very respectful and didn't speak about the woman's needs once they felt it was an environment with me where they could share. That to me that is against the stereotype of the Middle Eastern male who doesn't care about the woman.

Several other providers found some male family members dominating the woman's health encounter by dissuading her from getting birth control, or making decisions for her care. Providers also found women suppressed sometimes by the presence of her husband at the visit. Pam said,

They are a different patient with their spouse there; and he wants to be spoken to and she won't even look at me. And this is not always the case, but very often. But when the husband isn't there, they are friendly and often return a smile.

Kathy struggled with this issue and explained that in one case, she wanted to speak with the woman alone to assess for domestic violence and stated, "I think we need some time to talk by myself with this patient but I'm never sure if that is acceptable culturally you know in their culture and [if] that would be perceived differently." She admitted that she does ask for privacy and sees the patient alone but found that when family members are present, it presents a conflict for her in how she was taught to protect patient privacy.

In addition to the numerous ‘unknowns’ mentioned above, there were also other areas where providers had many questions about Iraqi Muslim cultural practices related to their health and or the health encounter. I will mention two stories that were presented with the most consternation for providers in trying to grasp an understanding of the differences in provider-patient values and beliefs. These providers explain how they struggled to understand a patient’s perspective of modesty and the strongly held belief of family honor as it is connected to female family member’s virginity before marriage. Both of these apparent struggles to understand a vastly different perspective stretched the involved provider and challenged her to meet the patient on a level of mutual respect.

Two female providers recall clinical encounters where numerous Iraqi women have refused a vaginal exam. In this context, she tells of one case that builds onto her idea of Iraqi women and vaginal exams. As a provider, she relates a story where she is confused and a bit frustrated. Not only is she unable to make a diagnosis but she cannot understand why a woman would refuse an exam because as a female provider, she seemed to fit the cultural criteria. She also realized that it was custom not to have an exam before marriage because this was believed that it would destroy her status as a virgin. She described the situation,

Like if you have any kind of vaginal exam before you are married that you will be like ‘devirginized.’ And I have patients with like chronic vaginitis or that is what it sounds like. They complain and they describe they will just [say], ‘I have a bump down there.’ Can I see? ‘Noooo.’ You know? And I am like please? Like how can I help you? You know it is like a little... it is like modesty gone horribly awry (laughs). You know what I mean?

She then evaluates this further and stated,

Like, it is great to be modest, and you know. But I almost think these are people, probably an individual, taking it pathologically to the next level. You know what I mean? Like really? I mean, I am a doctor; I am a female, like you know?

Another provider mentioned a patient who had been raped. This provider found it very difficult to comprehend that cultural norms surrounding rape prevented the patient from being marriageable. She admitted this was very different from her Western view and stated,

It was hard for me to go, 'Okay that's what is important to her.' And I sort of think, well any man that was worth his weight would think you are lovely and like that should not [matter] and you need to find a man that will appreciate you for who you are. Like that's very Western and I think that was a barrier for me to like just step back and say 'that is what is important to her, that is her culture, her family's view, everything.'

She reflected further on her own medical knowledge about family size and comorbidities affecting pregnancy and surmised, "So those things may get in the way of maybe understanding where someone is coming from or their decision-making process."

Providers frequently raised other questions about Iraqi patients' habits or customs that arose out of patient encounters such as, decision-making processes for contraception, dietary habits, and culturally acceptable exercise. Ben stated, "Things like exercise you know seems to be somewhat of a foreign concept and you take that a step further and the concept of a Muslim woman exercising. That is one of those cultural issues that may be a barrier to my usual spiel." Kathy found it difficult to define cultural practices broadly because of the variation that exists between people. She stated, "I've been kind of surprised you know there are some women who are traditional and culture is also broad and culture is defined in so many different ways like I can't stereotype all Iraqi women but um there are probably some themes."

In summary, providers identified Iraqi Muslim female patients by their outward dress, language, and national origin as well as their seemingly common traits identified through experiences in the health encounter. Although patients were identified primarily

as Muslim, this label was explained as cultural practices and gender was a main focus for providers. Providers conceptualized patient identity in terms of nationality and language but not race/ethnicity. Generalizations about Iraqi Muslim female patients also were formed from provider's perspectives of their clinical presentation that included high expectations from providers and treatments. Providers expressed uncertain inferences as to the origins of these expectations but noted significant patient frustration when expectations were not met. Few providers explored or were informed about the historical context of patient expectations. Iraqi Muslim female patients were identified primarily by outward appearance, which was also used to compare and contrast Iraqi patients among other clinic patients of refugee backgrounds. But Iraqi female patients were often fused with others who were either Muslim or wore a hijab. Many providers admitted that their vision was limited and fused, leaving the patient recognized but unknown in the provider's perception.

Measuring the Bridge's Gaps and Planks in the Fog

In this theme, providers assessed what is missing in the health encounter from both patient and provider sides. Differences and missing components in the patient-provider interaction were defined as gaps. These gaps focused on how cultural difference between patient and provider play out in the health encounter. To draw analogy to the bridge, providers give account of the bridge's footing, where patients must walk and they define both the planks and gaps. But while measuring or assessing the planks, questions are raised and assessment becomes questionable due to the fog. Evaluating the gaps in terms of provider efforts and patient outcomes is difficult in the fog. The fog represents

provider's questions about narrowing the gaps or how well their efforts addressed various patient perspectives and the underlying uncertainty in the evaluation process. As one provider said in reference to evaluating the quality of health care for refugees, "I don't know if it is better or worse care. I think it is kind of a mystery as to what is really going on sometimes." Although providers outline individual approaches to the encounter, looming in the fog are suppositions, assumptions and questions that remain about their style when encountering Iraqi Muslim female patients. Providers evaluated their ability to accommodate to the gap of difference and spoke about their limitations in the encounter, their cultural mishaps, and some patient limitations as well.

Approaching the Gaps

All providers agreed there were gaps in offering health care to Iraqi Muslim women and others who differed in language, culture, religion, values, and beliefs. Providers were asked to explain their mind-set and approach to working with difference and how they worked with or around the gaps, in order to accomplish their goals in the health encounter.

As they discussed their approach to differences between themselves and patients, providers defined the gap most often as culture but also included language, age, gender, background, knowledge of the health care system, and differences in understanding that stem from both culture and background. The conceptual approach to addressing the gap was most often stated in terms of "being aware" of issues, and disparities but also having an awareness of cultural norms for a particular group. This was stated by various providers as, "It's important to be aware that there are going to be differences," "The

basic thing is to have awareness,” and, “I don’t think it is that hard I just acknowledge that it exists.” Being aware was all one could really do, as Kathy stated, “So we just try to be aware, you know. Like I can’t change my race, I can’t change my religion or anything like that.” Julie added a rationale for being aware of differences and said, “Well, I have also heard that once the provider is aware of those disparities the poor outcome diminishes.” Jeff also affirmed the wisdom of being aware and stated, “the cultural gaps become an issue if you sort of pretend they are not there.”

When approaching the gaps, providers mentioned useful resources and attitudes for negotiating the health visit. Reliance on a good interpreter was mentioned by two providers as a way to negotiate the gap. Gaining knowledge was important for some providers, which included ideas such as “educating myself about different cultures as much as I can,” and “be cognizant of the [patient’s] background, be attentive to gender issues and their religion.” Ann’s approach included knowing cultural nuances and she acknowledged that every Iraqi woman is different. She explained, “Every person is different, right so they can say ‘*inshallah*’ [God willing] but it means different things for different people.”

Several providers felt it was important to consider the patient’s background or situation while in the health encounter in order to be oriented to a more sensitive and perhaps empathetic approach. One provider directly mentioned trying to be empathic by reminding himself, “to stop with the situation and say, ‘okay, if I were in this situation how would I react? And is that reasonable?’” Jessica alluded to a similar stance where she starts from a place of “mutual respect and curiosity” and asks questions about the patient’s perspective and experiences in order to “contextualize what this [health visit]

experience is like for the other.” This included asking patients about the Iraqi health system and health visits in order to understand patient expectations. She also mentioned identifying a common humanity in patients and realizing where they are coming from. By sitting and chatting to a patient, she explained what would be understood.

You would realize that they are human; they are a human being. They may have some different thoughts but like they have a mother, they have a brother, they have a sister. They are just like me you know in that. When I give talks, that is what I would tell a resident, ‘You are most likely fortunate that you haven’t endured what these individuals have endured to get here. But you should always think about what they have endured to get here because that may well impact how they are relating to you. That desperate need to get the MRI... that is what has allowed them to survive. So don’t just get mad at that; look at it and understand it and understand where it comes from.

Jeff also explained his approach was based in respecting the patient and understanding the patient’s past context. He said,

I try to be conscious of the cultural things that could come up... more about what any person has been through as opposed to specific gender or cultural identity. A lot of them have been through such terrible stuff that is more important.

Pam felt it was important with any patient to ask open-ended questions and let the patient guide and tell what they are feeling. She also felt it was important to orient herself to the patient’s context by acknowledging their past and present struggles. She stated,

These patients have been traumatized in their home country and then often they have been resettled to places where there have undergone traumatic experiences after the initial trauma and then coming to the United States can be very traumatic, I think especially for Iraqi patients. Many of them were professionals in their home country and they come here and are doing some job for them that they feel is way below what they are able to do in their home country. Um so I think just exploring those themes.

Cultural humility and respect were frequently mentioned attitudes informing a provider’s approach to patients. Jeff mentioned his initial approach to Iraqi patients. He said, “I think that being respectful and setting the stage for a good interaction is more

important than the recommendations that are made for seeing the person the first couple of times.”

Kelly explained her approach as one of cultural humility, which she defined as “asking and not assuming you know anything and find out what the patient’s preference is.” She rationalized, “we can try and memorize cultural norms, like all the women [are] like this or that, but it is not true, as we know.” Pam agreed and stated, “Cultural norms don’t hold fast for every patient, you have to have cultural humility and ask [the patient] and not assume things.” Donna included respect but clarified that it respect was an approach for all patients. She said, “You just need to know how to treat people with respect. So I don’t know if I would treat this population any different from anyone else.” Sarah stressed the importance of patient respect and autonomy. She explained the need to compromise because the patient is an “autonomous person.” She alludes to an example that runs contrary to her own beliefs of what she felt was healthy for a patient and concludes that understanding their point of view is impossible. She said,

So if she makes a decision like not wanting to be on birth control or wanting to have one more baby even though she is 45 years old or whatever, you just give them the pros and cons and respect their decision. And you try to realize that people are coming from a different point of view and there is no way you can understand that point of view because you are coming from a different one. You know?

Several providers mentioned taking an approach of being patient and giving more time to the encounter. This was tied to an approach to communication and use of limited clinic time. One provider was encouraged to be patient and reasoned, “Because things are going a bit slower and it is going to take twice as long.” But in this time, she explained that trust and relationship can be built. Jeff mentioned, “You sort of allow time to ask questions and keep it open enough and not be judgmental based on their heritage.” Donna

added, “Spend time listening to what they are trying to say.” Julie agreed that being a good listener was important and to use touch appropriately. She also advised, “Be open and accepting of their complaints, stay focused on the big picture and [do] not go down fruitless paths that is a waste of time.” Kelly mentioned, “Ask questions and take time to consider what is okay for them.”

Inspecting the Gaps through the Fog

Providers were asked how they were dealing with the gaps or differences between themselves and Iraqi Muslim female patients. They evaluated how they handled the gaps personally and sometimes included how the clinic as a whole was addressing cultural differences between staff and patients. Their comments provided perspective on their struggle in relation to their circumstances and shed light on individual actions that bridged cultural differences in their clinical context. Estimations of their individual performance in addressing differences were clouded by question that were most often focused on patient-provider cultural differences.

When providers were asked how they assessed their ability to address the gaps, some referred to themselves and the clinical staff’s ability to be culturally sensitive while others spoke in terms of making progress, or making mistakes. Many attributed their mistakes to lack of cultural knowledge or lack of skill to understand the patient’s past health context. The goal to prevent health disparities was alluded to along with being culturally aware and sensitive. But a clear evaluation of their efforts seemed unattainable and the goal of their efforts was vaguely referred to and therefore was not well defined. Providers responded in terms of working within a framework of cultural competency or

adaptation to various cultural differences presented by the patients that attended their clinic. They expressed uncertainty in how they were perceived by patients.

One provider mentioned a past point in time when providers evaluated themselves and clinic staff and recognized a need for change. In this clinic, providers started making improvements by educating clinical staff on cultural awareness and scheduling was improved with efforts to coordinate services with the refugee agencies. After explaining this, Ben surmised, “I think we still have a ways to go. I think even though supposedly I am aware and teaching about it I always make mistakes too. So we’re a work in progress.” He admits that addressing patient-provider differences in order to improve health disparities is on his radar and said, “...so hopefully we are doing better than average.” He noted that his awareness and knowledge of cultural differences has matured and stated, “It has taken me time to learn about and then to adapt my practice to meet those needs and I’m sure there is more that I should be doing... I am sure we all feel that.”

Other providers mentioned specific areas where they self-evaluated based on their understanding a patient’s cultural context. This included knowing a patient’s beliefs and how medical care was carried out in their country. Kathy found this knowledge to be helpful but challenging to understand and believe because some medical practices and beliefs differ greatly from U.S. practices. She stated,

And then I think trying to... and I don’t think we do a great job of this or I personally don’t but just trying to understand the cultural context the patient is coming from and then ask them what their beliefs are or how things were done in their own country because a lot of times things vary. They will say ‘when I was at home ...’ now I don’t know if this is true but patients will say, ‘Lortab was available over the counter’ or ‘every time I went to the doctor they gave me a shot and that took care of things.’ Or you know ‘we don’t believe in having mammograms because I don’t want to know if I have cancer.’ You know all kinds

of things.

Pam evaluated herself on incomplete cultural knowledge and acknowledges she probably made mistakes. She pointed out that she relied on others to direct and correct her in the encounter. She stated,

I read what I could but probably made mistakes...fauxpas (laughs). I think folks are very gracious and very kind and they probably don't say anything. You probably do things that you have no idea that you are steppin in it (laughs). And you don't know unless somebody is kind enough to tell you. Um and I think I was guided gently by the MAs or interpreters if I was ever stepping in the wrong areas (laughs).

Jeff acknowledged that his lack of exposure to Iraqi culture may be a source of patient frustration, but was not part of his frustration. When Jeff was asked if he had any common frustrations with Iraqi Muslim female patients in the health encounter, he stated, "No, none... frustrations for them actually I haven't been exposed to their culture."

In her evaluation, Kathy admitted to her struggle in declining a handshake towards male Iraqi family members or patients. She stated,

I have the bad habit of wanting to shake hands (laughs) that is my culture; I'm German... a firm handshake is appropriate! I know I do it all the time, I stick out my hand and I am like Oh! That's right... you may not want to do that (laughs). So that for me is hard. That is my culture. It's like I always greet people that way. So um, that's hard for me at times to readjust my thinking and not act surprised when they don't extend a hand out.

Donna had a similar struggle with not shaking hands with Iraqi men and stated, "It throws me off a little bit because some are very strict Muslims and I am not able to shake their hands and some of them are not and I can't always remember who is who."

Being cognizant of cultural differences, providers also questioned how they were perceived by Iraqi Muslim patients and if they were addressing patient health needs adequately. Julie felt the perceived cultural barriers made it more difficult to screen for

domestic violence but she suspected it existed. And like other providers, she found women refusing cancer screening and attributed to their lack of understanding preventive care but is uncertain about their previous health care. Pam questioned how she was perceived by Iraqi female patients. She explained,

I am very persistent that they do something. Like I constantly am asked to fill out this Department of Workforce services paperwork and I always give them a very short window and tell them, in 6 weeks you need to be going back to classes you need to be going back to work because I think that is important for them psychologically. What do they think of me? I really have no idea and I have often wondered.

Adjusting the Planks

There were several ways that providers accommodated to the health care encounter in order to work within the perceived barriers of time and various cultural differences. Providers recall instances where they used their position and knowledge to achieve their goals for the health encounter.

Providers shared instances where they accommodated to the patient in the health encounter. These examples can reveal how their approach was translated into positive action. The most frequent examples were in the form of communication. Julie gave several examples of teaching patients and would explain her assessment to the patient as an analogy of coming alongside her to take a journey and figure it out together. She also drew pictures and used examples to explain anatomical normalcy to some patients. Other providers mentioned explaining procedures, and checking for understanding.

Both Pam and Jeff spoke of creating a connection with the patient through communication that may have parted from the medical content of the visit. Jeff has a conversation at the beginning of the visit where he discusses nonmedical topics. He

stated,

[I] spend time at the beginning of the visit which is sort of you know the medical equivalent of 'drinking of tea' so you don't launch into some professional discussion without sort of setting the stage for communication.

Pam also offered discourse about nonmedical issues and referred to this as "creating a human connection." This she felt transcended everything else in the health encounter and was also important for her. She described it a warm and accepting place where trust could develop and empathy was displayed. She explained,

Listening is [the] key. I don't think that a lot of these folks have felt heard. You know they are shuffled through a process that they have a finite amount of time to get through. They have to hit all of these things in a short amount of time and they are trying to assimilate. So I think that being able to spend an hour or more and to really be able to sit and to talk and not always be directed to the outcome or the goal but just talk and just hear each other um that is key.

To adapt to issues of modesty and gender preference, Ann would remove male assistants from the room for an exam and switch the male for a female medical assistant when an Iraqi Muslim female patient was seen. Kathy would reschedule the patient if no female interpreter was available.

Two female providers mentioned using Arabic greetings with their female Iraqi Muslim patients and 3 others mentioned using touch to show empathy. Kathy reported that one person at the front desk of the clinic had put up greetings in Arabic and other languages so patients could see that upon checking in for their appointment.

Many providers mentioned explaining tests and procedures to patients and not assuming they had prior knowledge about them. Explanations were also part of negotiating the patient's felt need for expensive tests or the patient's refusal of examination or lab tests when the provider felt it was necessary. Both Sarah and Kelly discussed how they let the patient refuse a recommended test after explaining its purpose.

Kelly explained,

I feel like in some cultures they want to do what they want to do. And you can say 'this is why I want you to do this and this is okay, but ... okay, you want to do that, alright... I won't get mad at you, I will still see you...you can come back'... there is love (laughs) just let it go. You know? So people are adults and they can make their own decisions and you have to let them even if it differs from standards set for practice.

Ann sometimes struggled with a patient's request for expensive tests that may not give a clear diagnosis. After trying to understand what made the patient desire the test, and rationalizing that there is no need for it, she confessed,

So are there times where I may say, 'fine, you can have a chest x-ray because I'm tired of like continuing to battle and I might do that but I do it with low cost tests, and whatever but I am not going to do it with an MRI. That being said what is the context of someone that is so latched on to needing an MRI? And is that is the only way they are going to understand that they need to have surgery or that their knee is going to get better? There's a therapeutic value in that.

There were also several ways that providers incorporated cultural knowledge to influence the patient decision-making. Being informed by other Iraqi physicians of the status a physician carried in Iraq, she used this position of authority to persuade patients to follow a course of action. Kelly relates a story where she understood how some patients resigned to indecision on what she viewed as critical matters that affected health. She refutes the idea of patient resignation to God's will (*inshallah*) by trying to convince the patient with a new interpretation. She stated,

I really think your baby is in trouble. And they are like 'Well, whatever happens is God's will.' And I'm like no, no I'm like no. I'm like God doesn't want anything bad to happen to you and God doesn't want anything bad to happen to your baby. That's why God sent you to me (laughs). And God sent me to medical school. And God is saying take care of these ladies and these Iraqi ladies or Somali ladies and go work there and talk to them and so that's why God sent you to me, so I can save your baby. Or not save your baby but... or help your baby. A lot of people just laugh (laugh) you know what I mean? And they respond favorably.

Following this story she admitted, “Well I have just made it up. I don’t know if it is kosher. Or cool that I am saying it. Maybe I am breaking all kinds of ethical laws by saying it but...” Kelly knew enough about patient beliefs to adapt her message but she also reflected on the ethnical foundation of her information.

In summary, provider identified gaps in the health care encounter were recognized and attempts were made to accommodate to these. The approach to the gaps started with being aware, applying knowledge, fostering communication by listening, showing empathy, and in some instances, considering the role of the patient’s past and present context in light of their expressions in the health encounter. Some expressed the limitations in a set of prescribed cultural norms groups of people and yet providers based their own performance on knowing cultural norms and accommodating to them. Within these accommodations, providers sometimes struggled with their own values and foundational knowledge. In the end, providers were uncertain about how well they accommodated because there no means of clear Iraqi Muslim female patient feedback exists.

Repairing the Bridge

Provider participants explained the multiple challenges that they faced in meeting Iraqi Muslim female patients and in discerning and treating their health problems in light of the clinical system. They were asked what changes would address gaps and barriers in order to improve the health encounter. Providers gave several ideas for improvement when considering the differences that existed between themselves and patients that included issues of communication and patient expression and expectations, time for the

encounter, and changes in the clinical system.

Replacing the Cables of Communication

Improving communication was the most common suggestion to improving the visit. The ideas varied as to how communication could be improved and what this would accomplish for both provider and patient. Nearly all providers mentioned that a common language between patient and provider would be an obvious communication improvement. English language proficiency was proposed to solve many communication problems. The next best thing would be the regular availability of a skilled, culturally congruent female interpreter. Expressions of this idea varied.

Kathy suggested multiple language fluency for all people involved in the care of Iraqi women, rather than the patient's ability in English. She also mentions language as a point of comfort perhaps implied for provider as well as patient. She stated,

I would just wish the pharmacists were fluent in Arabic and that at every single level I wish that I just was multilingual, that my whole staff was multilingual (laughs). Well you know that we would have everything; that it would be 100% comfortable.

Most providers suggested that the patient have language comprehension. Patient language proficiency, which was implied as English language, would be helpful to deepen communication and give providers a clearer picture of patient preferences. Sarah preferred patients to have language comprehension "because once you have that we could talk about differences and she could express opinions and desires." Kathy gave a patient focused benefit to sharing a common language but also noted that it wouldn't provide cultural understanding. She explained,

Language wouldn't take away the cultural barriers but it would give them the

independence to ask their own questions at their liberty and not have to depend on the interpreter and risk the interpreter eliminating things or misinterpreting things.

A few providers alluded to clear communication from the patient that included self-advocacy, honesty, and relationship-building. Ann stated,

The thing I guess I stress to all of my health screenings is to have a medical home; really having a relationship with your physician. Make sure they know you and understand you and understand what your needs are and all those pieces. And being clear about what it is you are asking for um... yea, I don't know, I don't know if I should say things like, 'you should follow the doctor's instructions...if you don't feel like you can follow the doctor's instructions, then explain why and explain your concerns.'

Closely tied to forthright, clear communication was the idea of "being more engaged in the process." Some providers felt that Iraqi female patients needed to say more about themselves in the visit and to communicate in a way that allowed for fuller self-expression. Ben explained that an Iraqi woman in the presence of her husband may not get all of her questions answered so he suggested that the visit would be improved if someone could "make sure they [Iraqi female patients] are speaking up for themselves enough." Jessica agreed that communication needed to be improved by "advocating for yourself." Sarah also preferred that Iraqi female patients be more direct with their needs and they should know their views are considered by the provider. She stated that patients should "Know we value their opinion and if they had a preference, to be clear about it up front instead of giving body language hoping the doctor gets it. We want to value their preferences." Donna's advice was, "For her to be clear and honest of what worries her and why she made the visit... it helps the doctor know how to help."

Reorienting the Planks

Apart from communication, providers had other suggestions about how Iraqi women could reorient their perspectives or work on their circumstances in order to improve the visit. In these suggestions, perspectives and opinions held by an Iraqi woman would need to be changed or developed. Within these suggestions, providers alluded to the perspectives held of the context of Iraqi women's lives. Only one provider had no suggestions. When asked about suggesting changes to improve the health care encounter for Iraqi Muslim female patients, he stated, "I don't know if I would presume to do that. I guess I couldn't say. No I wouldn't have any suggestions."

Several providers suggested the encounter could be improved if the patient could view herself as a partner in health care. This included the idea of patient taking initiatives to be involved in her health and also to adjust some expectations. As discussed, several providers felt that patients held very high expectations of the provider and the medical system. One provider reviewed how she received multiple requests from patients for various things such as bed bug control and filling out forms for work. She also mentioned that Iraqi patients seem to feel that the provider or the prescribed medication can solve many if not all problems. She felt the patient-provider encounter could be improved by patients taking responsibility for their health and having a realistic expectation of what medicine can accomplish. She explained,

I think there is sort of this sense that medicine can solve all of these issues or that there is sort of one blanket cure for these problems or that there is something that you as a provider can do to make everything better. I think that is one of the hardest things is that we can't fix everything and some of these problems are going to be chronic or...there is also a very strong sense that the medical provider can deal with your employment situation and your housing situation... But having the sense of self-empowerment and seeing yourself as having the ability to carry out your own health care and being healthy. I think that would be very helpful for

me to improve the visits and encounters.

After explaining that very few Iraqi women get out of the home and work and that they seem isolated, Sarah suggested that Iraqi women could get more out of the visit if they were just settled and integrated in life. She stated, “I think if the goal is for them to be assisted in American health care system; they would need to be assimilated into the culture in other areas of their life as well.”

Restructuring the Other End of the Bridge

Provider participants suggested a few changes on improving the health encounter that included various parts of the health system. Two providers suggested adjusting schedules to allow for more time for the health encounter. Kathy suggested, “Scheduling that meets their need for more time to accommodate communication.” In light of all the health issues and the need to establish a trusting relationship, Pam suggested a longer time for each visit. She said, “So I think that being able to spend an hour or more and to really be able to sit and to talk and not always be directed to the outcome or the goal but just talk and just hear each other um that is key.”

When asked about improvements to the encounter, some providers expressed the need to increase provider and staff knowledge of cultural differences. Two providers gave instances of cultural problems that arose when patients encountered referral providers who were unfamiliar with patient cultural preferences, past trauma, and struggle to negotiate the health care system. In light of this, Ann suggested that providers be more aware of the patient’s background, especially their trauma, to facilitate their struggle to gain access to care. She explained,

It can be a big deal to even get someone to the surgeon's office or whatever and if there are all these individuals who are not aware of that individual's trauma and if they don't have access to care, then they won't get the care they need.

Ben was unique in that he mentioned the clinic visual environment. He stated, " Ideally you know it would be great if they could walk into a waiting room and it would be more something they are used to but we have one size fits all."

In summary, with limited evaluation, providers recognized the need for changes in the health visit in order to meet the needs of Iraqi Muslim female patients. Improved communication and gender congruence were repeated again as obvious areas in health service that could improve the health encounter. Improvements and changes carried implications for assisting the provider to understand the patient. Not only was it suggested that the system change, but ways in which other providers and the patient could change were noted. Some patient changes (embracing concepts of a medical home or seeing herself as a partner in her own care) would require remarkable changes in the individual patient perspective. These suggestions revealed further depth in the difficulty of understanding in the provider- patient relationship.

Providers' experiences and perspectives include frustrations and challenges in discerning the health needs of Iraqi Muslim women within the limited confines of the health system. Gaps created by health system barriers and by patient-provider difference are persistently apparent in the health encounter and can be identified through the lens of a postcolonial feminist framework. This framework will be used to elucidate findings in the discussion.

Discussion of Health Provider Participant Data

Health providers in the health care encounter are confined to clinical norms created by the established health system. They operate in this prearranged environment that is established by the dominant society. Providers are in a designated clinical location and operate from this firmly established position. They are also born from the dominant society and therefore are assumed to share similar values as those that operate the system. Their lives are woven from the same cultural fabric as the health system, which may make it difficult to see any need to question changes to the system, especially those that represent a small minority of patients. The provider's role in this position is at times powerful, challenging, and constrained. The analogy of the suspension bridge fits the provider's perspective. From this stable, established end of the bridge, patients are viewed in their journey to meet the provider and engage in the health encounter.

The Provider Side of the Bridge

The analogy of the bridge is useful for describing the patient-provider encounter. The patients start at one end of the bridge and attempt to make their way to the provider who sits in a clinic on the other end of the bridge. The bridge sits over a chasm that represents the health care system in the U.S. The bridge symbolizes the patient's journey to meet with the provider and the challenge of the interaction within the health encounter.

From the provider's view, the bridge is situated across a familiar but deep chasm. This side of the bridge is where the clinic is located; it is built of stone, and sits firmly on the rocky edge of the chasm. As the bridge continues toward the patient side, it transitions from solid stone to a suspension bridge. On the suspension bridge, the

platform is composed of planks but in places, there are large gaps between planks, some missing planks, and several that appear loose. Planks represent challenges that patients face in crossing to the provider side. Providers rarely peer into the chasm due to the high stone walls and their busy patient-filled clinics that take their time and attention. The provider side of the bridge is much higher than the other end where patients come into view and for this reason, it is often covered in fog, making a clear view onto the bridge difficult. The fog and the large numbers of patients interfere with discerning the identity of patients on the bridge. In order to make their work manageable, providers have categorized patients by their presentation (language, outward appearance, demands, etc.) at the encounter. But this method often fails because some women tend to dress similarly but may speak a different language or have a different nationality or race/ethnicity. Unfortunately, there is not enough time at the encounter to discern individual differences. But providers must do their best with these limitations and see as many patients as possible in their clinic. They try their best to adapt to the individuals they meet but with limited vision and limited time plus the demand to see many patients, communication is compromised and often provider and patient fail to understand each other and the quality of the visit is diminished.

When the fog clears, providers can see a fair distance onto the bridge and view the oncoming patients. But there is a vast distance between provider and the patients on the bridge. This distance represents existing differences that either thwart the visit or invite patient or provider adaptations to make crossing feasible. Over time, providers have noticed that patients have fallen through gaps in the bridge or have been blown into the chasm by strong winds. Unfortunately, there is no other path to meet the provider. It is

not in the provider's scope of practice to rescue each patient far down the bridge. The bridge has its own problems and providers cannot leave their post. Despite the difficulties and obstacles to crossing, several patients have successfully crossed and meet the provider.

In this discussion, I used a postcolonial feminist lens to add clarity to the patient-provider relational aspects of the health encounter. Specifically, I addressed areas of power, subjugation, representation, and knowledge within the health encounter. I also took note of provider self-perceived differences with Iraqi Muslim female patients such as race/ethnicity, religion, culture, and language and considered how these interfaced with issues of power, knowledge, representation, and subjugation within the patient-provider health encounter. Within this discussion, the various perceptions and experiences of primary health providers are drawn upon to answer the research questions.

Unseen Barriers on the Bridge

Colonial Construction

As noted previously, the bridge is colonial in nature and the provider's side of the bridge makes this most apparent. The provider's side of the bridge is a formidable stone structure that has been established for some time and appears immovable. It was built by the dominating majority who had the will and resources to set up the system long ago as new arrivals to this geographical area. For the majority of inhabitants, the bridge is a workable solution for patients seeking a provider as long as they conform to the set standards that were put in place when the bridge was founded. Yet it appears that an increasing minority of patients struggle on the bridge, and it appears they need to make

personal adjustments in order to cross and ultimately meet the provider. In order to successfully cross, they will need an exceptional interpreter or better yet, English language ability. They can make it across if they gain an understanding of the system. It would also help if they were able to be a little aggressive to push their way across in places. The established bridge as the only way across the chasm has worked well for the majority; there is little felt need for change. Therefore, no alternative exists. From the provider's perspective, it is hard to see and distinguish the several small groups of new people on the bridge because of the fog, the vast distance to the travelers, and the constant variety of people on the bridge. It is continually difficult to understand individual traveler-patients because of time constraints. Unfortunately, these need to exist and are expected because it is a market-driven bridge where numbers of patients meeting at the encounter is equivalent to reimbursement. Providers are stuck on their side of the bridge and have restrained movement. They have limited time and resources to consider any alternative if to the present system, should the thought ever arise. They rely on what they have been trained to do; with hands tied, they reach for the most expedient means of diagnosing and treating the patient.

Power and Subjugation

Power and subjugation are key mechanisms operating in a colonial relationship and provide a lens for a postcolonial perspective. Power may circulate throughout the system and it may be oppressive and productive, subtle, and rooted in daily context; it may be unnoticed (Foucault, 1980). As previously mentioned, providers are delegated power in the visit when patients defer to the provider in order to achieve the common

goal of finding a diagnosis (Pilnick & Dingwall, 2011). Although power rests within the provider's knowledge and position, it may not always produce patient subjugation. Subjugation can arise from many sources, be subtle, and vary in its impact and context. Power is embedded in the health care system and in the assumptions that undergird its workers. The context of providers entrenched in the health system suggests compliance to health system goals that may supply providers with numerous expectations. These may include ideas about what needs to be accomplished to keep the system operational and efficient, such as the number of patients seen in a specified time frame to produce sufficient revenue. Iraqi Muslim female patients are a potential stress to the system goals because they take additional time to understand, and they often present with multiple problems that are complex to unravel due to their barriers of language, culture, and past trauma. In many instances, it is necessary to limit the visit time in order to meet system goals and demands. In some instances, providers are cognizant of their power in the position they hold and acknowledge their privileged place among the dominant majority who constructed the bridge. But this does not preclude them from being frustrated by the system.

Time is a source of provider power that intersects with communication. Providers have the power to turn off the visit by stopping the communication. Ben was self-effacing when he acknowledged this. He pointed out that power was derived from language wherein the patient could not effectively be self-assertive in requesting more time as some English-speaking patients would. Time constraint is a system demand that has underlying implications for generating revenue, and limiting conversation that tightens the squeeze on both provider and patient. Patients may be suppressed by the system

demand that translates into the providers' need or ability to curtail health encounter time. Patients needing more time are then subjugated or silenced by limited expression of their health concerns in the encounter. The outcome for the patient is an increased number of health encounters, additional tests, and added patient frustration. When time is narrow, the encounter becomes a source of frustration and becomes an insufficient means to accomplish both provider and patient goals of treatment. Providers who have expressed their need for more time are in essence working with hands tied in order to meet system demands; they are stuck on their side of the bridge and do not know how to effectively move within the squeeze of time constraints. With their hands tied, they reach for what is within their grasp. Sometimes more laboratory tests are used to find a diagnosis rather than the difficult and time-costly route of patient communication. The provider-directed encounter must yield to the most urgent medical problems discernable rather than patient-felt concerns. On this solid, immovable end of the bridge, it is the patient's English inability and lack of self-assertion and clarity that is the cause for subjugation through the provider's use of power to control conversation and time. Providers acknowledged lack of time to understand the patient, especially their beliefs, and preferences. There was not always sufficient time to hear their story and establish a broader foundation for the relationship. This left providers to function with many unanswered questions that were potentially important to individual patient treatment such as preferences, beliefs, and values. In the end, patients were left with the responsibility to be understood and to explain themselves more fully but were bound by time.

Providers also carry expectations of patient performance in the system in order for it to operate. Communication is one example of expectations that arise out of the

dominant cultural context. Providers are attempting to carry out the encounter within the guidelines of patient-centered care that include understanding and confirming the patient's perspective; understanding and considering the patient within their psychosocial context; attaining a shared understanding of the patient's problem and its treatment; and forming a partnership between provider and patient wherein patients share in decisions, power, and responsibility (IOM, 2001). Providers struggled to attain this and were severely limited by language barriers and time constraints. Many providers expressed a desire for Iraqi female patients to communicate more clearly about their health problems, and alluded to language difference as a communication barrier. This is congruent with current studies. When language differences exist, patients have been found to be less expressive and communication is hindered for both patient and provider (De Maesschalck et al., 2011). In the present context of the health encounter, patient centered care is strangled if not unattainable when cultural and linguistic barriers occur. Although barriers exist for both provider and patient, patients were responsible for this barrier by not speaking English. It was their lack of English that thwarted the 'usual spiel' of a provider.

Knowledge

Providers recognized Iraqi female patients by their higher level of education as compared to other refugees. This was interpreted by some providers as being demanding as they knew what tests they wanted, and what technology was available, and the patients requested it. In the provider's experience, their request was not based on sound medical knowledge or system rules of economic conservation. For some providers, patient

knowledge of Western medicine practices was some relief. These patients were also identified as having more familiarity with the medical system and tests and therefore required less provider time and effort to explain tests. Listening to other forms of individual patient knowledge was not directly commented on in the provider interviews, which made it difficult to assess if this knowledge was suppressed by time and communication barriers or merely untapped by providers.

Providers' knowledge and power intersected within the health encounter in various ways. Through provider knowledge, diagnoses were made, referrals given, and treatment was rendered. Within this knowledge, they maintained the power conceded to them by the patient. Provider's knowledge about Iraqi Muslim female patients was received from patients and the few interpreters or medical assistants who could inform them about the culture (religion, values, and beliefs). Providers were knowledgeable about general areas of patient preferences as it related to the intersection of culture and treatment such as Ramadan, gender-concordance, and modesty and accommodated their care based on their knowledge. However, they operated with a knowledge deficit about the individual patient and some of the finer details of her culture and historical/political context. These deficits were expressed in the many questions that providers raised in the interview process that concerned patient's beliefs, values, and preferences and were based on patient-provider cultural/religious differences. With unanswered questions, providers often functioned on the basis of their assumptions and conceptualizations derived through their experiences with patients. According to Smedley et al., (2003) this mirrors the mental process in medical decision-making wherein an assessment is reached based on observational inferences about the patient problem and where judgments are

made without complete information. These authors found that communication barriers, time constraints, and lack of resources (excellent interpretation) lead to cognitive short cuts where providers mentally group clusters of information needed to make diagnostic decisions. Van Ryn and Burke (2000) pointed out that the same line of thinking progresses when stereotypes and prejudices are produced; a short cut is needed and is formed on a deficit of information. Persistent provider questions raised in the interviews indicated that providers operated with a significant deficit of information about a patient and how she was informed by her culture. If there was time for communication and adequate interpretation, these questions could be answered and a greater depth of patient understanding may have resulted. Operating with a deficit of information leaves providers open to producing stereotypes, and poor understanding of individual differences that could affect medical care. Without intervention, it is likely that the patient-provider relationship would not foster empathy or understanding and that provider-driven health education and treatment communication would suffer. Although some providers did acknowledge time given to establishing the relationship with the patient through communication and a trusted interpreter, it is likely that more time would have helped foster provider-patient understanding.

Within the framework of patient-centered care, providers hold the additional expectation that the patient be informed, understand, and participate in the encounter so as to be an active participant in care, which in turn helps the provider to accomplish her/his goals. Some providers suggested that if the patient is an active participant, even a partner, they will get more out of the visit. The providers carry knowledge as prescriptive information; this is a message that will enlighten a patient about their medications or

treatment and their health. The knowledge/message is given with the intention of helping the patient understand and comply with provider recommendations. The intended message is immutable knowledge based in scientific evidence. It appears to be a standard message and not a message adapted to the patient's frame of reference. The repercussion is limited knowledge for the patient; she can understand only as far as she is able. In a few instances, providers indicated that the quality of care was based on what the patient can take in. It is the patient who is held responsible for understanding by adapting to the system structure. Adapting is strongly implied by understanding English, understanding the nature of the system, or by the explanation/navigation of an exceptional interpreter. Some providers were concerned about the transaction of knowledge/message to the patient. In the case of explaining medications, this was a source of frustration for providers. They also expressed important questions about what the patient was able to understand as interpretation was the only means of communicating and it was difficult to understand clearly what the patient was thinking.

Representation

Iraqi female patients were represented in a number of ways that formed a basic provider conceptualization of them as a group. Provider knowledge and clinical experience with Iraqi female patients as well as other refugees provided a basis for characterizations that were unique to these patients. Some providers adamantly felt that the media had no bearing on their conceptualization of Iraqi female patients or Muslims while others entertained this avenue as a possibility. The question of the media influence appeared to be a new idea for many providers and like some of the interview questions

signaled a need for provider self-examination.

Comparing Iraqi female patients to other refugees helped providers to distinguish differences between groups and it helped them form a conceptualized group for these patients. It is likely that this grouping is a cognitive short cut that helps providers anticipate patient expectations for the visit and make any accommodations. It is also an avenue for stereotyping (van Ryn, 2002). This process is explained by psychology and cognitive science as a schema. DiMaggio (1997) describes schema as a thought pattern or behavior that defines an organized pattern of thought or behavior that arranges categories of information and the relationships among them. He explained that in a rapidly changing environment, creating schemas is a useful way of placing a perceptual framework on new information so it can be interpreted, understood, and recalled; schemata are likely to remain unchanged but can represent some aspect of the world, or a system of organizing and perceiving new information. New schema can be rapidly organized and can be accessed quickly without complex thought and therefore can be used as a cognitive short cut (Nadkarni & Narayanan, 2007). Categorizing Iraqi female patients into a set of characteristics is an example of a developed schema formed on personal experience and can be accessed quickly by providers.

Providers categorized Iraqi Muslim female patients on the basis of their most prominent clinical characteristics. Rarely, some characteristics were linked with presumed historical/political contexts (feeling owed) and social contexts (educational level). Iraqi female patients were conceptualized as a group through repeated characteristics such as the need to get into a specialist quickly, requests for expensive tests, and the presentation of many physical complaints. Some providers attributed this to

an assumption that they were used to being seen quickly. Other providers may have correctly assumed that an Iraqi woman's previous medical context may be driving her current demands, but such assumptions were seldom verified by asking the patient about medical care in Iraq. Providers tended to label the conflicting expectations as patient misunderstanding; providers do not hold power nor do medicines. The implication is that the health system is not going to change; patients must adjust. The frustration of several Iraqi Muslim female patients was noted by many providers in response to the system. Providers also spoke of the struggle in explaining the system goals of conservative treatment trial before expensive tests. In a few instances, a provider has given in to a patient's demand for testing for reasons of proving there was nothing wrong, or for the psychological satisfaction it may bring the patient.

The problem with categorizing people was evident in the story of the Iraqi woman who had a true neurological problem that nearly went undiscovered because of the psychosomatic label. The failure of providers to discern patient complaints correctly because there are too many presented is potentially a deep pitfall. The overwhelming representation of Iraqi Muslim female patients as mentally stressed and psychosomatic seemed to land on both sides of the spectrum for providers: either possible neglect of the issue and its impact on health or as a persistent, unchanging characteristic that put the list of expressed ailments into question because of the potential to be just another psychosomatic complaint. There is the risk of missing something important because it would take too much time to review all health systems or to talk about each complaint; or when exploring a complaint, it could be brushed aside as a stray psychosomatic ailment. The provider's ability to cognitively shift through the patient presentation with minimal

conversation, limited understanding, and restricted time needs to be appreciated. It is a difficult task even for the seasoned provider.

Comparing various cultural groups that presented in the various clinics was one way of distinguishing Iraqi Muslim female patients from others and categorizing them into a discrete group that could be defined and managed through some predictable cultural expressions. This cognitive categorization worked fairly well for providers on a time budget, but it was not without mistakes and groups (i.e., Muslim women) became fused. All providers worked in clinics that had significant populations of refugees, which facilitated the fusion of patient identity; it was like fog that easily clouded their vision. Having extensive contact with both Iraqi and Somali women on a conversational level in the past years, it became evident to me that provider fusion of Muslim women with refugee backgrounds was happening during interviews more often than some providers realized as they characterized what they thought to be Iraqi women. Nonetheless, refugees were compared and this included interesting categories that may carry across refugee populations in providers' minds such as degree of suffering and PTSD, religion/culture, and educational/medical understanding. The outward appearance of the hijab was likely the greatest point of Iraqi Muslim female patient representation and also the point of identity fusion with other Muslim female patients. The obvious lack of identifying any racial/ethnic difference points to the prominence of religion/culture identification of Iraqi Muslim female patients in provider conceptualization. Hijab as a symbol of being Muslim seemed to override distinctions of race, nationality, or even language. In fact, no mention was made of Arab ethnicity/race, which may indicate the prominence of being identified as Muslim. As stated previously, intersectionality is

evident by all other aspects of identity falling into this one principle category of ‘Muslim female.’ With this comes the main provider accommodations to care mentioned as Ramadan, modesty, and gender congruence. This lumping of individual characteristics (language, religion, culture, and nationality) into the category of ‘Muslim female’ leaves occasional gaps in provider thinking where questions are raised when the category fails to encompass a broader view of the individual. All of the unknowns between provider and patient cannot be reconciled but improvements can be made.

Building a Stronger Bridge

Providers are expected to remain on their side of the bridge in the established clinic. Their glimpses that carry them beyond their setting are momentary and foster questions that may feel impossible to address due to time and workload constraints. Vision is also limited by their experience and context as they are embedded in the dominant culture and function efficiently in it. Although some make a good effort, it is hard to imagine life for those who are not part of the dominant society. Nonetheless, providers have attempted to do the best they can with hands tied.

Recognizing Gaps

From the bridge, providers made several glimpses onto the bridge and recognized some of the struggles of Iraqi Muslim female patients. Providers acknowledged and evaluated gaps in the system and communication was the largest gap. But several acknowledged that it was not just a matter of language and good interpretation but also understanding the patient was contingent on cultural understanding. A few providers

recognized that culture was not a fixed set of beliefs, values, and norms for a particular group, and that individuals varied. Several providers mentioned an approach that was patient-led, and that relationships must begin with some understanding of the individual's life, which included some initial time for patient-provider communication. Despite these good intentions and attempts, providers had their hands tied by time, poor interpretation, and cultural unknowns. The best intentions to accommodate to the patient rested on flimsy knowledge that often was not individual-specific. However, there were providers who clearly expressed an avenue of intent that was clear and hopeful. Jessica spoke of probing deeper, and considering the patient in light of their context, past experiences, expressions, and requests; this produced knowledge that formed more empathy. Most providers recognized and accommodated to the main areas of patient-provider differences that largely affected care such as adjusting medications in Ramadan, providing gender-congruent care, and modesty. They also realized more could be done.

Evaluating the Provider's Side of the Bridge

Evaluation of the provider in the context of overall patient care of Iraqi Muslim female patients remains as an unknown. There is no current method of evaluation for patients who speak no English, so evaluation becomes conjecture. Providers could only point out instances where they thought they were meeting the patient's needs. Several providers candidly admitted their flaws and based performance on how well they knew the culture and by the accommodations they made. Many providers may not have had the time or incentive to evaluate the bridge or propose changes. The health care chasm may appear too deep and complex and impossible to grasp. Their firmly established side of

bridge can appear to be immovable. Nonetheless, providers spoke of a willingness to change even if impetus and direction were lacking. Bridge reconstruction included ideas based on firmer relationship-building through establishing a medical home, greater time for the health encounter. In some cases, providers expressed a desire for more patient involvement and clear expression in the encounter. Other ideas included patient evaluation, provider education, and a clinic with some familiarity in the environment that would acknowledge patients and make them feel more comfortable. It is clear from these ideas that improved patient-provider communication is needed and dependent on time and good interpretation. Communication is the key to patient expression and will likely improve provider-patient understanding in all aspects of the individual patient but only if time allows.

Reconstruction of the bridge is in order. Providers acknowledged their limitations, desires, understanding, and intentions within the health care encounter with Iraqi Muslim female patients. Their attempts to function within the encounter with hands tied by time, lack of good interpretation, and limited individual understanding is acknowledged and provides a foundation for further evaluation. In the following section, I will identify common gaps and barriers recognized only by patients, providers, or both patients and providers and discuss the implications for the health encounter.

CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study was to explore the perceptions and experiences of the health care encounter from the viewpoints of Iraqi Muslim female patients with refugee background and primary health care providers. Critical ethnographic methodology was used with a postcolonial feminist lens that highlighted the differences (race/ethnicity, gender, language, religion and nationality) between patient and provider. I will refer to the findings and discussions presented in previous chapters in order to elucidate the similarities and differences between provider and patient then draw conclusions and discuss clinical implications. Finally, I will present recommendations for policy, practice, and future research.

In this chapter, three main areas will be highlighted from previous chapter discussions. It is important to note that these topics are interrelated and interwoven with each other but are discussed separately. The discussion of these main points is not exhaustive but represents the major conclusions from this study.

The Health Care Environment

The environment of the health encounter is largely dictated by the institutional nature of the health care system. For the purpose of this discussion, the health care

environment consists of the components pertinent to this study and the clinics that were observed and referred to by the participants. The clinic environment also includes the unseen web of power embedded in the levels of governmental and health-insurance regulation and oversight of health administration payment and programming, which in turn determines clinic goals, time parameters, language, and resources to accomplish the patient visit. This clinic structure and the forces that drive it often go unnoticed by those within the system because these forces are a reflection of the dominant society and have been historically embedded in the system. In both Iraqi and U.S. health systems, patients visit a physician in a clinic to receive treatment for a medical problem. However, despite any similarities, the two systems differed in critical areas. For Iraqi patients, they encountered health visits within a system that is Western. The driving force of the system includes policymakers and administrators, insurance executives, and medical personnel (Feagin & Bennefield, 2014). Providers function in this setting and reflect the goals and values of the system. Although the main focus of this research is between provider and patient, the health environment plays a pervasive role in this relationship. The health environment is a reflection of the health system as an institution. The health environment includes the people in the clinic, the physical clinic environment, and the expectations of the people functioning within the environment. As such the environment reflects institutional actions and expectations for clinic functionality that are culturally derived, and set in place by administrative personnel. The following discussion will also focus on how the interaction between patient and health provider is dominated by the constraints and barriers of the health environment.

Institutional Racism

Institutional arrangements can be seen as acts that exclude or differentiate some individuals based on their difference and this is one type of racism (Clark et al., 1999; Fagin, 2011; Goldberg, 1993). As previously noted, the definition of racism contains the idea of exclusion and this can operate on the basis of aspects other than race such as language, appearance, and knowledge. For this discussion, institutional racism includes acts that limit access and opportunities to patients because of their difference (culture, language, religion, gender, etc.) from the present dominant Western system. The institutional health care setting places these patients at a disadvantage in relation to the white majority. It is important to note that the institutional structure also puts the providers at a disadvantage to provide quality care. The aspects of the clinic environment, time parameters for the visit, language difference, and provider resources will be explained as key factors that contribute to institutional racism.

The Clinical Environment

In this study, clinics were marked by near exclusive use of English. This language use puts all non-English speakers at a disadvantage in understanding the system, the provider, and the staff. English language proficiency is discursive power and provides a patient with the ability to understand the system, and self-advocate for their needs and for information. Likewise, lack of English proficiency is disempowering in multiple ways. Dependency on an interpreter places the patient in a vulnerable situation where knowledge and access are mediated and potentially interrupted by misunderstanding and time limitations. The non-English speaking patient becomes dependent on many others to

guide her through the system, make appointments, interpret instructions, educate, and be her voice within the encounter. When her voice is not directly heard, her power of self-advocacy is significantly compromised.

The absence of any familiar signs or symbols (i.e., Arabic) in the clinic environment is a means of exclusion. When an Iraqi patient is surrounded in the clinic by all that looks unfamiliar and is not comprehensible, she is reminded of her difference, otherness, and foreign status. Signs in English and health information in English prevents access to beneficial knowledge and this deficit speaks to another degree of social exclusion for the non-English speaking patient.

Structure of the Health Encounter

The institutional decision to set time limits for the health encounter is one of many acts that place patients at a disadvantage in accessing resources. It may be a disadvantage for any patient but it is especially true for patients who lack English language proficiency. As presented in the findings, time limitations for the health encounter restrict conversation between patient and provider, which opens the door for miscommunication, misrepresentation, and potential mistakes in diagnosis. Limiting time for the health encounter discounts individual differences in patient needs. Some patients may require more time due to language or health concerns. The provider recognizes these time constraints but continues to work within this confinement despite the stress it sometimes causes for both provider and patient.

Some providers expressed concern about time limits and productivity requirements and suggested a few ideas for improvement, but it is unclear how this

institutional norm can be altered and who would take responsibility to make any changes. It is also important to note that providers had the power to enforce the time limits or extend them, but the patient has no voice in this matter. In this case, the patient is situated in a powerless position due to the system structure and is unable to express her health concerns because of time constraints. Patients' encounters with the current health structure surprised the women because of the differences from previous experiences in Iraq where they could unleash all of their complaints to a provider who would assess and treat or refer. In the Iraqi context, patients were not seen as different; they did not need to explain themselves nor were they subjected to an interpreter. In the U.S. context, patient's knowledge of the system was labeled as cultural difference or lack of assimilation.

The clinical structure of health visits also includes the use of templates for documenting and conducting the encounter. The obvious discord between patient and provider definition of culturally appropriate questions, especially in light of accompanying family or interpreters, speaks to the dominant culture's hand in the institutional setting. In the health encounter, some routine questions formed from a template and asked by medical assistants or by providers were culturally inappropriate and may have easily contributed to emotional or psychological distress for many of the Iraqi women and for some, it may compound their current emotional distress. Template questions as such were an example of institutional racism where on the institutional level, there is no awareness of an alternative cultural perspective. Here, it is likely that the provider or the health institution would claim no intention to harm, but in fact, harm may result from the emotional distress of asking sensitive, private questions when others

(interpreters, family members) are present and the nature of the questions include unspoken topics in their culture.

Access to Resources for the Health Care Encounter

Institutional lack of resources for minority groups is another form of institutional racism. Both providers and patients agreed that financial resources were insufficient to meet the health needs of Iraqi Muslim patients or any refugees. Time limits and referral possibilities for Medicaid were a frustration for both provider and patient because medical needs were difficult to discern and address within the terminal time limit set by federal authorities. Access to care was also limited by resources provided by refugee agencies in the form of timely transportation and timely, skilled interpretation. Both provider and patient suffered by using inadequate resources (unskilled interpreters who were often late or not gender-concordant) or by conducting the visit without these resources, which adversely affected the quality of communication and hence provider understanding about the patient's concerns. These issues in turn limited the provider's ability to diagnose and treat, consequently leading to more tests. Working with limited resources also hindered the patient-provider relationship and further reduced channels of communication. Providers also voiced lack of cultural resources to bridge the differences between themselves and the patients. Not only were resources (gender-concordant, skilled interpreters, time) inadequate but sometimes unavailable even after requested.

Gender-concordant care (interpreter and provider) was also noted as a resource that was not always available. Patients' requests for gender-concordant care was known by all provider participants and attempts to accommodate to the patient's need for this

along with patient modesty were acknowledged by both providers and patients. One patient's story of preparing for a health encounter by dressing in light clothes so as to avoid the need to be undressed speaks to an understanding that modesty and gender-concordance has a high chance of nonaccommodation in the health visits, particularly in visits where the patient may encounter an unfamiliar provider such as in the emergency department. But sometimes, even when gender-concordant care was requested in English prior to a visit, it was not always granted. System resources do not exist to provide patients with gender-concordant care. This request is outside the normative behavior for the majority of patients so resources are not always available or aware of how to accommodate to this request. In this way, institutional racism is evident by its failure at times to provide for requested resources.

In this study, institutional racism appeared in many forms. It is manifested in how it limits material conditions and access to power and is often normative and viewed as an inherited disadvantage (Jones, 2000). In regard to power, institutional racism is manifested in differential access to health education materials, informational signage, and quality interpretative services. Additionally, institutional racism inhibits the functioning of the clinic as well as the patient's ability to access care, and the provider's ability to effectively communicate, diagnose, and treat. In effect, the multiple forms of institutional racism disempower the patient by leaving her voiceless and dependent on scarce and often inadequate resources. Not only does the clinical environment deter quality care for Iraqi Muslim female patients, but the encounter with the provider also can impede health care. The provider-patient relationship contains multiple aspects that limit health care. Discussion of these and their clinical implications will be addressed next.

Provider and Patient Interaction

The exchange between a provider and a patient in the health care encounter is colored by knowledge and power. Both knowledge and power operate from the location of each person within the encounter and within society. The interplay of power and knowledge between providers and patients reveals the extent of understanding that each has about the other. Knowledge is also linked to a cultural past that informs the present interaction and sets the stage for expectations within the health encounter. Knowledge is informed by representation. Outward appearance plays a major role in knowledge formation that can be a source of profound difference between provider and patient perspectives. In this section, I discuss the expressed knowledge of provider and patient as it intersects with cultural awareness and representation. Then, I draw conclusions based on comparisons of providers and patients' expressed knowledge and experienced power in the health encounter.

Knowledge in the Health Care Encounter

Patient and provider knowledge becomes the basis for expectation and actions within the health care encounter. Each individual comes with a knowledge set that is formed in a societal and cultural milieu, which includes formal education, one's own ideas, and experiences. In its cultural milieu, this knowledge is instilled with beliefs and values and forms the basis of actions. Commonalities and differences appear when comparing provider and patient knowledge. A great deal of work and will is required of an individual to obtain an understanding of another's knowledge and expectations when it arises from a vastly different context than one's own. Work in the form of

communication is necessary in order to obtain understanding. Resources such as skilled interpretation and time are essential in order to exchange knowledge, expectations, and to share ideas, values, and beliefs. It is apparent from this study that several factors inhibited knowledge sharing between provider and patient. Therefore, each party formed ‘truth’ about the other from limited information. Foucault (1977) has asserted that knowledge is a form of power, which determines those who are subjects of knowledge by possessing it and who are its objects by being known or not known about. In this study, both patients and providers acted on their limited knowledge of each other during the health care encounter. Providers sometimes used knowledge as a form of power. In the following section, I will focus on knowledge enacted in the health encounter as an expression of past cultural lessons, education, and experiences that formed expectations, enacted power, and located difference in the patient-provider relationship.

Limited Knowledge

It appeared that providers gained most of their knowledge about individual Iraqi Muslim female patients from repeated patients’ visits, but this knowledge was incomplete and was often limited by time and communication. At first glance, provider knowledge of the Iraqi Muslim female patient was functionally complete and included awareness of Islamic based practices (gender-concordance, modesty, medication adjustments for Ramadan) that often allowed the provider to extend basic accommodations to Muslim Iraqi female patients.

Although their knowledge may have been more extensive than some referral providers, it still was insufficient in aspects that were identified by patients. Many

patients reported being discounted by not being heard, and by not having the time to explain the extent and number of their health problems. Both providers and patients found too little time to lay a foundation for understanding. As a result, providers formed a ‘truth’ about the patients that characterized an Iraqi Muslim patient as demanding, having too many complaints to address in one visit, and a high likelihood her complaints would be psychosomatic. This characterization of patients may form a basis for making cognitive short cuts in the visit where labels of ‘Iraqi’ and ‘Muslim’ are used by providers. These labels allow providers to operate on a preset notion of the patient, thus closing the possibility for an alternative or broader understanding of her as an individual. This preset notion may form into an expectation in the provider’s thinking that the long list of patient complaints would need to be cut short due to time limitations and possibly the likelihood that the complaints may be labeled as psychosomatic. The provider used this limited knowledge as power in several instances to discern what constituted a valid or serious complaint and to curtail patient expression. Only in a few instances, the disempowered patient voiced a complaint against this power.

Knowledge and Religion

At times, the conceptualization of religious or spiritual orientation became a point of stark contrast when considering patient and provider knowledge. Provider knowledge of Islam appeared limited to the basic elements that intersect with the health encounter. Providers’ lack of knowledge was evident in their many questions. Questions concerned more details on how Islam was lived and how it informed patient perspectives such as in family involvement in decision-making. Providers were influenced both by their own

spirituality and religious orientation, which often reflected the social norm of stifling discussion on this potentially sensitive topic or reducing its appearance. This perspective muted the topic of religion and obscured it from being fully recognized for the prominent force it holds in many patient lives.

Not only was the topic of religion obscured, but it was fused with culture and language. In the patient electronic record, only one provider could identify where religion was located and most providers preferred to identify the patient in the record as a refugee with need for an Arabic interpreter. It appeared that patients were one of the best sources of Islamic knowledge for providers and patients were often eagerly open to discuss their beliefs, but providers restricted their own knowledge by curtailing discussion or allowing the barriers of time and communication to override their curiosity. Although about half of the providers identified themselves with a formal religion, it was not fully apparent that this fostered a deeper awareness, understanding, or opportunity for patient religious expression or explanation. It is likely that the many provider questions about the patient's broader social context and beliefs could be answered through conversations with patients, had time permitted.

Knowledge Assumptions and Limitations

Poor communication and lack of time led to deficits in knowledge for both patient and provider. These elements sometimes allowed providers to conceptualize the patient as a case of poor understanding when in reality, the patient was put in a situation where she must bear the burden of understanding instead of being understood. Several assumptions were made about patient knowledge and values that impeded understanding.

Providers' limited knowledge of the patient had several repercussions.

Providers have been taught the ideals of patient-centered care (IOM, 2001) and may attempt to fulfill the ideal of forming a patient-provider partnership in care wherein patients share in decisions, power, and responsibility. Providers may feel that sufficient power is given to the patient in this regard. Nonetheless, patient-centered care sets the expectation to involve patients in their health care through shared responsibility for applying health knowledge that is often conveyed primarily by the provider to the patient. The provider's limited knowledge and barriers of communication with an individual Iraqi Muslim female patient afforded no avenues for determining if this value laden ideal is also shared by the patient or if the patient has the health literacy to be well-informed about decisions. Patient accounts of the expected provider role and both patient and informants' explanations of health care in Iraq point to the novelty of this approach for the patient. When decision-making was not a shared value with the patient, it became a source of frustration and confusion for both patient and provider.

When providers attempted to communicate health information, they often perceived a lack of patient understanding, especially when the idea of adopting personal health behaviors was introduced as part of the treatment. Patients were perceived as demanding and highly educated, which may have led providers to assume that patients had access to basic health education and disease prevention concepts from which to draw upon when they were requested to take responsibility and make changes in their health behavior. No doubt providers tried to assess patient understanding within the visit, and took great effort at times to help the patient understand treatment or change behavior, but it is apparent that this effort did not stem from a depth of knowledge about the individual

patient that could have informed the provider's approach to giving health information or making assumptions about the patient's health literacy.

In addition, providers may have assumed that patient's understood their responsibility for their own health and embraced the role of making personal health behavior changes. However, Iraqi participants may have had different ideas about their role in their own health behaviors and been unable to perceive themselves as empowered to change their health through their own behaviors.

Preventive care is not part of patient knowledge in Iraq as was pointed out by this study's informants. Additionally, most patients perceived that providers had the resources to fix health problems and this was a patient expectation. Preventive care and health maintenance would most likely be new concepts for the patients in this study and not part of what would normally be heard from the provider. Written health education materials adapted for these patients did not exist. In the end, patients were left with the limited bits of information given through an interpreter. Many patients left the visit confused and frustrated only later to be labeled as 'noncompliant.'

In order for a patient to take a prescribed role of responsibility in her health, knowledge is needed; more importantly, her knowledge, values, and beliefs need to be assessed first then incorporated into suggested practices to improve health before requesting her acceptance of responsibility for her health behaviors. It is not that providers did not try to impart understanding about health information to patients; some of them gave an incredible effort with the strong intent to help. Unfortunately, their efforts were uninformed about the social, cultural, and educational background of the patient and her ability and desire to agree to this underlying notion of responsibility. With

more information about the individual patient, the ideal of shared responsibility in health could have been evaluated for its appropriateness to individual patients according to their value orientation.

Provider knowledge and responsibility had limits as well. It is significant to note that when a patient's explanation of her cultural situation was explored further, as in the cases of the rape and the refusal of pelvic exams, providers confronted a limit to their own understanding of a patient's situation. Despite their efforts and desires to understand the patient perspective, patient's explanations were so far from the provider's cultural viewpoint that the woman's socio-cultural position and perspective became unknowable. When a situation is determined to be unknowable, then the responsibility to know is removed. If the patient is unknowable, then the incentive to know diminishes and her situation is likely to be labeled as unknowable and the provider is no longer responsible to know. Undoubtedly when this mindset prevails consciously or unconsciously, it has the potential to further stifle communication and interaction between patient and provider.

Knowledge and the Provider's Role

Iraqi Muslim female patients also formulated generalized opinions about provider's roles and communication based on their past experiences in the Iraqi health care system. Often these expectations for providers' roles and the health encounter added to their frustrations. For example, preconceived notions about providers may have been crushed when providers were not seen as being the bearers of the 'best medical care in the world' by referring to the computer to give information, or by sharing any uncertainty

in their formulation of a diagnosis or when treatment included prescribing a trial of medicine or choice of treatments. From the provider's perspective, these actions can be considered part of shared decision-making. It is apparent that patients were not ready to take on the shared decision-making partnership espoused in patient-centered care. Additionally, patients were not looking to make a choice about their treatment but they were seeking a voice to explain their perceptions and ailments. From the contextual knowledge of a patient's past health care experiences in Iraq, listening to complaints was one expressed role of the provider. Partnering in their treatment ran contrary to the expressed role of a provider (physician) who should know disease processes and treatments and authoritatively render a confident prescription or at least refer for further tests in order to come up with a correct solution to the patient's health problems.

Knowledge as Empathy

Several but not all patient participants emphasized the importance of communication with the provider that included positive affective components as some termed 'psychological comfort.' This idea was exemplified best in foreign-born providers who could give direction and encouragement not only in the medical care they rendered but for the immigrant journey that often included the struggle to work through many adjustments such as grief, depression, and linguistic obstacles. These providers and others who gave encouragement, listened with empathy, asked fewer questions, and gave useful direction were those who tempered the encounter with a level of patient understanding that put patients at ease. These providers also may have fulfilled the expected role of a provider. The foreign-born providers were noted in some instances to have expressed a

shared understanding of the immigrant journey that may have communicated empathy and encouragement that outweighed any negative aspects of seeking health care in a foreign environment. Empathy is likely one of the strongest components of psychological comfort. In this regard, several patients in this study expressed agreement with other research findings; empathy is a critical component in care and a necessary communication component along with respect, listening, and attention to socio-cultural aspects of illness (Teal & Street, 2009). Other research has marked provider expression of empathy as one the most important aspects of communication according to patients; it is communicated by an extensive exploration into the patient's substantial concerns and expressing validation (Bertakis, Franks, & Epstein, 2009). It is probable that empathy may be an unexpressed need that resides in any patient. Empathy and psychological comfort may be an even greater need for patients who come from a traumatic context of war and are still dealing with multiple losses and grief while attempting to negotiate life in a foreign context. Affective care may have a greater role to play in the health care encounter for patients who experience daily vulnerabilities while seeking health care.

In conclusion, knowledge is informed by culture, education, and past experiences and this creates a basis for both patient and provider expectations in the health encounter. Provider knowledge included a general understanding of Iraqi Muslim female patients that was limited in depth and restricted by excluding a wealth of individual patient knowledge. Likewise, patient knowledge embedded in past socio-cultural learning created expectations of providers' roles that did not meet their needs within the health care encounter. Patient and provider interaction that is connected by empathy may override some aspects of knowledge deficits in the provider-patient relationship.

Representation in the Health Care Encounter

Representation becomes part of knowledge formation about others and plays a critical role in the health encounter. Perceptions and representations of others also define a ‘truth’ (Foucault, 1977). Both provider and patient carry a ‘truth’ based on experiences, perceptions and representations. Additionally, this ‘truth’ was informed by the cultural, political, and historical location of each provider and patient and was influenced by their position in the health system. Representations sometimes assisted providers to form labels for Iraqi Muslim female patients; at times, this formed a conceptualization where patients were labeled as noncompliant or lacking cultural assimilation, as evidenced by their inability to fully understand the local health system or function within it. Patients’ knowledge also included representations of themselves and perceptions of providers. In this section, representation as knowledge is discussed with focus on cultural aspects of the health care encounter.

The Hijab’s Signal

The hijab is a focal point of provider representation of the Iraqi Muslim female patient and also a statement of identity that varies among Iraqi Muslims. It becomes another aspect of fused identity for the provider and allows patients to be labeled.

Providers formed ideas about Iraqi Muslim female patients as a group that was signified and represented by the hijab. Presence of the hijab identified patients as different from the majority of patients. The hijab signified a merging of culture, ethnicity/race, and language into one label of ‘Muslim’ although some providers verbalized that this was not always the case. Patients in this study agreed with findings in

the literature where they identified more strongly with being Muslim than with other labels such as nationality or ethnicity (Ahmed, 2001). But for providers, this label was limiting and often included a knowledge-representation set for an Iraqi female patient that encompassed other common attributes (language barriers, limited or no insurance, a male relative to negotiate, a laundry list of complaints with possible psychosomatic roots, and demands for technologically advanced medical tests). At the basic level for all providers, the hijab signified Muslim beliefs, medication changes for Ramadan, and accommodating to modesty and gender-concordance, all of which required the provider to act on a certain set of knowledge that was different from the majority of patients. This provider knowledge-representation set categorizes patients into a group and thus obscures individual differences (Kelly, 2009) and allows for the intersection of race, culture, language, nationality, and religious differences to be fused into one label. This intersection was seen when several providers mixed Iraqi patient stories with those of Somali, Afghani, or Iranian women. Fusion of Muslim identity was one reason among many for limited understanding of the individual Iraqi Muslim female patient.

Culture and Assimilation

Despite several providers' spoken desire to understand the patient, they often pointed to the patient's culture or lack of English language proficiency as barriers when struggling to help patients understand instructions about medications, or other necessary health promoting activities. Some providers pointed to the need or desire for Iraqi Muslim female patients to assimilate to the health system and the normative cultural context that they now live in so that they may effectively navigate the system and absorb

important health messages. This colonial view of patients who do not fit in is seen in a negative light that colors all that they represent. As Memmi (1965) pointed out, “the colonizer is preoccupied with making him undergo this urgent change” (p. 83). Within this assumed need to change, providers also may have supposed that Iraqi Muslim female patients actually desired to assimilate to the American culture. The idea of cultural assimilation sits in stark contrast to how various Iraqi women expressed their own identities. This became evident when they were asked to explain the meaning of wearing the hijab.

The Hijab as Identity Assertion

Iraqi participants attached distinct and individual meaning to wearing the hijab. Most pointed to how it identified them with being Muslim and that it was a choice. Historically, the hijab has been cast off or worn for many reasons and it has been connected with Islamic discourse and has been assigned significance in various political discourses (Ahmed, 1992). As Ahmed (1992) points out, views of women wearing the hijab are varied and for some, it may be connected to a conservative lifestyle, or following a more fundamentalist Islamic code while for others, it may also be a symbol of Islamic feminism where women assert equal rights. Outward identification with Muslim dress brings with it significant social and psychological dimensions. As Ahmed (2011) pointed out and as echoed by many participants, there is a sense of peace and comfort in aligning one’s self with Islamic values and in joining a community that shares similar values and fosters a common identity. Additionally, Ahmed (2011) noted that wearing the hijab in America, as in other places, signified resistance to perceived

discrimination and prejudice; it makes wearers visible as the dissenting minority living in the midst of the dominant society. With this stance, they affirm their heritage and values and challenge the inequities of racialization while calling for justice (p. 210). Elements of these ideas were found among some of the Iraqi participants. The hijab signaled difference and identification with a set of values that providers are obligated to understand and accommodate. Consciously or not, embodiment in the hijab and Muslim dress makes an Iraqi patient's presence a bold assertion of her identity. It is likely that some women expected reciprocal activity by those whom they encountered in the health visit.

Many women expressed an eager willingness to discuss their religion while others felt it did not need to be part of the health encounter inquiry, perhaps for fear of it being a point of discrimination or because they could not see the potential gaps in care it could create for the provider. Even though providers in this study were aware that the hijab signaled their need to accommodate, some patients gave accounts of encounters where other providers' knowledge of the patient's need for modesty was uncertain and so patients accommodated by wearing light clothes so as to avoid undressing for the medical exam. Accommodation to their needs in the health care encounter was never assumed by patients.

Cultural Accommodation

Providers have an unequaled task in synthesizing a great deal of information in time-limited patient visits. The routine of the patient encounter is disrupted by the discomfort of the unknowns that are attached with the visit of an Iraqi Muslim female

patient. When providers evaluated their abilities to accommodate to Iraqi Muslim female patients, they referenced their cultural knowledge set and their ability to accommodate to differences. Some providers admitted that their knowledge often fell short or was not acted on in the right moment. The juxtaposed stories of handshakes in the health encounter illustrate both the literal and symbolic gap between provider and patient norms. A female provider recounts accidentally offering her hand to greet a Muslim male and quickly withdraws with apologetic embarrassment, yet justified it as a learned behavior embedded in her heritage that is automatic. A young Iraqi woman participant recalls refusing a male provider's outstretched hand of introduction and then remembers seeing the provider's reaction of nonverbal reserve and limited communication for the remainder of the encounter. She pointed out that if the provider does not want that awkward moment, then they should know whose hand to shake. In many instances as these, Iraqi Muslim female patients attempted to assert their deeply held values by speaking up about their needs while in many instances, providers struggled to gain and use the cultural knowledge-set at the right moment.

Communicating in the midst of differences is a complex and often uncomfortable struggle for both patients and providers. It is obvious that a deeper level of mutual understanding is missing. Patients alluded to this numerous times. Patients pointed to instances where they appreciated the acknowledgment of Ramadan and being Muslim but also declared that at times, the value and importance of this was unacknowledged and displayed through attitudes where providers failed to inquire or even consider alternative accommodations to the routine treatment. Through patient comments, it became evident that provider knowledge and understanding lacks the necessary depth about the patient's

context to communicate effectively to individual Iraqi Muslim female patients. Likewise, patients may not fully understand the providers' barriers to gaining a fuller knowledge about individual patients.

Both patient and provider struggled to accommodate to their differences within the health encounter. Each person functioned from a vastly different past that was informed by unique socio-cultural lessons and experiences. The health encounter is a limiting environment for knowledge sharing and therefore lays the foundation for misinterpretation, misrepresentation, and consequent health disparities. The health encounter as a point of human relations has profound clinical implications which I will explain in the next section.

Clinical Implications

Institutional Racism

The potential impact of institutional racism is wide and varied. It is poorly studied in regards to health institutions and its impact on health outcomes (Feagin & Bennefield, 2014). It is known that social exclusion of any type can produce depression (Brondolo, Brady, Beatty, Pencille, & Contrada, 2009), which is a significant point given that many of these participants were already burdened emotionally. Institutional structures compromise patient-provider communication by time restrictions, lack of quality interpretive resources, and lack of gender-congruency so that during the encounter, the patient is likely to be less verbally expressive about her health needs, which in turn decreases provider communication (De Maesschalck et al., 2011). As noted in the data, a female Iraqi Muslim patient may very likely be less expressive when language

differences exist with her provider and when gender-concordance is not available with the interpreter or the provider. Some providers admitted that this may lead to errors in diagnosis or increased testing and a consequent increase of health costs. Requesting a female provider can delay appointments and allow health conditions to deteriorate or require an emergency visit, which increases cost and disrupts continuity of care. Lack of gender-congruent care can cause a female patient emotional duress as she must function outside of her cultural values at times, exposing herself to a male provider when this may cause cultural distress and increased anxiety for someone who may be already trying to cope with stress, depression, and anxiety. As an alternative to living this experience against her cultural norm, she will need to cancel the visit, reschedule, and delay treatment. This has the potential to further burden her emotional and physical health.

The institutional environment plays a significant role in defining the health encounter due to its structure and normative actions that reflect the dominant society. Some of the institutional norms can act preferentially for those patients of the dominant culture and act racially towards patients outside the dominant culture. Institutional norms can and potentially lead to poorer health outcomes for patients who are not part of the dominant culture. Other factors can potentially affect patient outcomes. In the next section, several aspects of provider and patient knowledge will be discussed as factors that influence the health care encounter and possibly affect patient health outcomes.

Biases and Stereotypes

Several aspects of the health care encounter allowed room for misunderstanding, stereotypes, and labeling. The specifics of patient identity were often missed due to

several aspects included in limited provider knowledge. Limited knowledge becomes the potential foundation for building stereotypes and biases.

Providers often operated on a limited knowledge set about the individual patient due to a lack of time to fully discover a patient's values, beliefs, and concerns. This allows the provider to function on assumptions and form stereotypes. Generalizations about patients can create a blind eye to characteristics that are unique to an individual's medical problem, thus allowing the provider to misdiagnose. An example of this was the case of a patient who was labeled as having psychosomatic symptoms when a neurological condition existed.

Relationship building through active listening, respect, attention to socio-cultural aspects of illness, and identifying patient perspectives run counter to stereotype and bias formation and likely would result in improved provider-patient understanding and nullify the poor health outcomes linked to racism such as psychological distress (Brown et al., 2000, Kessler et al., 1999), increased risk for mental disease (Kessler et al., 1999; Ren, Amick, & Williams, 1999), and poorer health status (Brown et al., 2000; Leibkind & Jasinskaja-Lahati, 2000). This is particularly important because some Iraqi Muslim patients may already be suffering from emotional distress due to past circumstances (Laban et al., 2005) and may be at risk for mental illness due to societal discrimination as a Muslim (Hassouneh & Kulwicki, 2007). Providers may add to this stress unknowingly through the use of labels, stereotypes, and biases.

Additionally, providers may continue to act on limited knowledge by denying a patient her voice within the health care encounter. When patient expression is limited, provider knowledge fails to expand. Providers then miss the opportunity for patient

knowledge that informs providers of new perspectives that could potentially deepen provider awareness and understanding of the patient. This knowledge could potentially answer many of the providers' questions and open the door to new avenues of interaction and accommodation to a patient's needs. Importantly, expanded patient voice can potentially give providers clarity of information when forming a diagnosis. Additionally, voiced patient knowledge could clarify expectations of the provider, broaden provider knowledge of patient values and beliefs, and give insight into patient-felt priorities and concerns. Patient knowledge would give additional information whereby providers could tailor patient education and improve communication in order to more effectively meet patient learning needs. Shared knowledge exchange between provider and patient would likely lead to better explanation of new modalities of care, clarify treatment rationale, and provide a foundation for relationship built on mutual respect and trust. This in turn would give opportunity for patient psychological comfort and diminishes the opportunity for stereotype formation. Giving an avenue for patient voice provides an environment of cultural safety where patients are free to express and be accepted for their person and identity.

Knowing Culture

Providers functioned on the bare basics of information that was formatted as a cognitive short cut with only the essential elements from patient information appearing to take a role in any clinical decisions. The factors above raise the question of what patient information is actually necessary for the provider to give effective care or at least not to produce detrimental effects from the encounter. Patients reported that providers had some

basic understanding of cultural norms that interfaced with the health care encounter but that this knowledge set often failed to emit understanding between patient and provider, and discounted the importance of held beliefs through limited accommodation to the patient. Although several providers had cultural knowledge and acknowledged that culture was dynamic and not static, this like many other sets of knowledge fell short of creating a level of patient understanding that would put patients in a comfortable state. Knowing about the patient's cultural norms and practices is a start and part of what is needed, but it is not enough. In conjunction with knowledge, an attitude of empathy and humility is needed. This was described by several providers as their approach. Nonetheless, patients cited it was often missing. An attitude of empathy and respect has been proposed to override issues of difference (Street et al., 2008) and is the key component of affective care. Acknowledging beliefs and values of the patient is one possible means for empathy. Ways of crossing the cultural divide and lessons in cultural competency are in need of revision so that differences can be bridged in more meaningful ways.

In conclusion, the multifaceted interactions in the health care encounter may go awry in any direction and contribute to health disparities. Smedley et al., (2003) asserted that within the health care encounter, discrimination is to blame when disparities are apparent, but outlining the specific factors that lead to this is difficult and research is lacking. It is apparent that the current system is not providing either patient or provider the opportunity to fully engage with each other in order to have an effective, meaningful, and trusting relationship within the health encounter. As one patient declared, "I'm comfortable with her [provider]; she understands me." Understanding may be complex

but achievable. In the following section, I will offer recommendations for improving provider and patient ‘truths’ to more accurately reflect the position and values of individuals within the health care encounter and suggest a means of achieving this.

Clinical Recommendations

In light of the clinical implications of institutional racism for both provider and patient, it is surprising that it has not been sufficiently addressed. Throughout this study, issues with the health system that are raised by Iraqi participants include some of the same system problems that affect nearly all patients such as limits in time, provider and patient communication, and limits on the number of health issues addressed. In this section, I will make recommendations that address policy, practice, and future research.

Bridging Diversity as Priority for Patient Care

It is a difficult and complex task to address cultural competence in a way that truly affects the provider-patient relationship. There are many approaches to training in cultural competency as well as consensus on stated goals, but efforts appear to have fallen short. In offering recommendations for improving cultural competency I will address changes needed for policy, clinics, personnel, and patients.

Impetus to change must encompass all participants who influence the health encounter from the administrative level to the patient. Efforts need to include dissemination of information about the present clinical challenges facing providers and patients, and coordination of change that involves appropriate stakeholders in order to reform health services.

First, administrative personnel and those involved in health policies need to be informed of the needs of providers and refugees within the health visit before they can embrace the desire to improve the clinical experience for patients. Findings such as those presented in this research may be a first step in helping stakeholders at the state level to be aware of the health encounter experiences of minority groups and the need for resources to meet their needs. Ideally, presentation of these needs at this time would give impetus to Medicaid reforms and the establishment of medical homes in order to improve services for marginalized groups and allocate funds to services for those with specific needs, such as refugees. Medical homes would be ideally self-assigned and integrated into areas where others received care. Several discussions of key stakeholders may prove fruitful for coordinating and informing reform efforts. Specifically, those involved in administering refugee services at the state level (Utah Office of Refugee Services, International Rescue Committee and Catholic Community Services, Asian Association, etc.) and those allocating Medicaid funds at the state level need to be informed about the health experience of refugees in order to work together with local clinics that provide services to large groups of refugees. The input from refugee service groups who interface daily with refugees and use federal dollars to meet refugee health needs will help inform and coordinate care with those who administer clinics for refugees. Their knowledge will help design services that improve management and coordination of transportation and interpretation at the health visit. They could provide input into creating medical homes that would more adequately address patient needs and be within the reach of various groups of newly arrived immigrants. Coordinating efforts directly with clinic reforms may improve the efficient use of federal money spent on refugee health services.

Secondly, changes to the clinical structure (addressed in detail below) are necessary to broaden patient-provider communication and thus foster better understanding and relationships. Changes to the clinical structure need to work in tandem with cultural competency training of all clinical personnel and clinical administration.

Cultural competency training with its set of values, attitudes, and skills needs to be imparted to clinical administration as well as clinical personnel in order to create a culturally safe environment. The Australian Human Rights Commission (AHRC) (2011) has defined cultural competence as a set of behaviors and attitudes that are expressed congruently at the personal and institutional level and work effectively to bridge cultural differences. This encompassing idea acknowledges that awareness of cultural differences is important but actions must include much more and focus on the ability of the health system to improve health and wellbeing by accepting and incorporating room for various cultural expressions into the delivery of health services. In order for this to occur, the health system and its workforce needs to value diversity, have the capacity for cultural self-assessment, institutionalize cultural knowledge, and adapt service delivery so that it reflects an understanding of the diversity between and within cultures (National Health and Research Council, 2006). When clinic administrators have put in policies for change, then clinic personnel would be supported in their efforts to restructure the clinical environment and to make personal changes to provide an environment that supports cultural diversity. I will offer some recommendations for change in the following sections.

Cultural Competency Exchange

Cultural competency training is one area that could help providers and clinic staff in broadening their perspectives of patient's both within and between cultures. In order to move beyond awareness of cultural difference, providers and office staff would need to be engaged in cultural competency that effectively assesses their own cultural stance, and brings hidden stereotypes and biases to the forefront. This engagement in culture would need to be supported by policy initiatives that acknowledge provider and staff training as an ongoing priority. A multilevel approach must be embraced and include extensive input and interaction with others who are marginalized by the health system. A cadre of diverse voices teaching and interacting with those of the dominant culture would assist clinic staff, providers, and administrators to realize their position and how it impacts patients of a different cultural context.

Ideally, patients would be a major source of information in this training that would include not only cultural information but a broadening perspective of their historical and social context as individuals. Patients as teachers would give validation to their voice. Listening to patient knowledge would promote their sense of their own belonging, and contribute ideas that promote cultural safety in the clinic. Multiple sessions of dialogue could fill the deficits of knowledge but also give opportunity for patients to incorporate culture into the health system and clinic environment. In the next section, I will suggest practical initiatives that have clinical implications and work to improve communication and relations between communities, individuals, and the clinic.

Restructuring the Health Encounter

As one provider suggested, time needs vary for patients as individuals given that some patients require more time than others. Time is of the essence in understanding an individual patient, and as mentioned, patients who vary in their values, beliefs, and language. Provider openness to patient knowledge by listening and learning are initial steps to transforming that knowledge into care practice. In light of the communication needs of non-English speakers, an increased time allotment based on patient need may help patient expression and provider diagnosis. Providers can maximize the benefits of their knowledge-power by integrating a deeper understanding of patient's socio-cultural context and its contents. In order for this to occur, an initial visit could be scheduled that includes an adjustable time to assess the patient's needs.

The initial visit could include the patient's family members for support and input into the care. Ideally, this would also fulfill the goal of creating a family medical home for the patient. This initial visit would include informal discussion with the patient, her family, and a health care team such as a social worker and a health guide, clinicians, and staff. The purpose would include obtaining a comprehensive understanding of the patient and her social context through varied team perspectives. Physical, mental, and social needs could be addressed by a team approach that would likely give a more comprehensive outlook of the patient and provide an avenue for sharing responsibility and communication in health services. A patient profile would be created as part of the referenced medical record and focus on the patient's need for information, emotional support, and logistical support. It would identify the patient's preferences in regards to language, and cultural practices so that this shared information would not need to be asked in follow-up visits. From this integrated approach to care, an overall plan with the

patient's input could be made with referrals outlined, health encounter needs assessed (i.e., interpretation), and time allotment proposed for the next visit. Roles for gathering and verifying information would be shared among clinicians and staff so that everyone could become familiar with the patient and develop a relationship with her and her family. The formation of this clinical relationship with the patient would supply the patient and her family with the understanding of a medical home and clinic resources. In this environment, the patient would have voice to inform the health team of her needs and she would be the guide for quality improvement by giving her feedback to the clinic. From the written and evolving plan, staff would be informed by consensus as to the minutes required for this patient's next visit in order to address social and health issues.

In addition to individual care of patients in the privacy of the health encounter, other sessions could be provided for general information at the clinic where groups of women with similar needs could receive supportive advice about health and navigating the system from mentors and health guides. Patients who have been in the system longer could also participate as group advisors, informing newer group members about health care and how to access resources. Group activities forming around the clinic are likely to support the development of new communities that can address issues for patient care and inform the clinic of what is needed in the environment to promote health education and cultural safety.

Improving Clinic and Community Resources

The gap between health clinic and refugee agencies could be addressed in several ways. Iraqi female patients with or without English language proficiency could benefit from a health navigator who is culturally, linguistically, and gender congruent and part of

the health system. As health navigators, their role could be expanded within the clinic and they would also serve as a case manager. As a resource to the clinic, the health navigator could address communication needs, health system direction, and provide physical presence support for the Iraqi female patient. The health navigator would be a cultural and health system broker who would facilitate the health encounter for both patient and provider by fostering expression and cultural understanding in both directions. Ideally, this person would be a resource for health education and improving the clinical environment with signage and other additions that would welcome patients with some familiarity. She would participate with the clinical staff to help inform them of the patient's perspective and keep them up to date with each patient's case. She could also help foster patient groups and communities and could be a main source of provider education on cultural safety issues and patient perspectives.

In summary, the current primary clinic system inhibits relationship-building between patient and provider and is in need of restructuring. Cultural competency training has not given providers sufficient foundation for bridging the cultural gap with patients who differ from the dominant majority. Improvements in relationships between provider and patient need to come from a comprehensive desire to understand people who differ from the dominant culture. Initiatives must be embraced and supported throughout all levels of clinic system in order to make positive change. Patients' voices must be heard in order for medical clinics to become to actually become medical homes where cultural safety is realized.

Recommendations for Further Research

There is a link with health inequities and poorer health outcomes for patients who are not of the dominant culture. Smedley et al. (2003) has pointed out that discrimination in the health care encounter is part of this problem but identifying the specific factors that lead to this is difficult and research is lacking. Several methods of research may help in unraveling the link between health inequities and discrimination.

Research of larger groups of Iraqi patients may shed more light and variation on those factors that produce barriers between patients and providers. Surveys that are culturally appropriate and include evaluation of clinical services from the patient's perspective are needed to provide ideas for better patient accommodation. It would be beneficial if research had more complete inclusion of experiences and ideas from interpreters and the broader community that interacts with newly arrived refugees. The input from these groups would encompass a broader assessment of issues in the health encounter that could inform providers and administrators of refugee issues that could be addressed in creating a clinic as a medical home for refugee families.

Participatory action research is one research method that can be used to identify specific problems from Iraqis and other refugee groups within the health system. In this research, patients ideally would be empowered to inform those in the health system of their needs and then become the power behind the changes that are needed.

A review of innovative clinical initiatives for minorities and refugees that have been tried and evaluated could offer creative ideas and solutions to improved clinical services for other communities that struggle to meet the diverse needs of refugee communities. This is particularly important as the U.S. health system is in transition and

being restructured with medical homes.

Conclusion

A postcolonial feminist perspective as a theoretical lens enabled closer examination of participant perspectives and experiences within the health care encounter. Critical ethnographic tools provided rich data from which to gather participant's perspectives about the health care encounter. By taking a critical stance, this research revealed the struggle between various providers and patients within the health encounter to understand and be understood. It is apparent that differences of language, religion, experience, education, gender, and race/ethnicity created formidable gaps that need to be bridged in order for the health care encounter to function effectively.

This study highlighted the importance and prominence of social and cultural influences that play a role in the health encounter. By giving heed to these influences, it has become apparent that racism is a reality within the health system and may be found in many forms, some subtle and some obvious. It will remain as a force linked with health disparities until it is recognized and addressed by those who maintain power in the health system.

At present, the ways of bridging the gaps between provider and patient understanding are dysfunctional. Both providers and patients will continue to struggle in the health encounter until it is restructured into a place that provides cultural safety. It is hoped that the results of this study will be used to contribute to the knowledge needed for substantive changes this to take place.

APPENDIX A

RECRUITMENT FLYER FOR IRAQI PARTICIPANTS

You're invited to Participate

.... If you are Iraqi, Muslim and a woman 18 years old or older

A research study is being conducted to learn about your experiences and perceptions of your health visits. It is a study specifically for Iraqi Muslim women. The aim of the study is to improve understanding of your concerns and desires in a health visit. Your ideas and opinions about your health visits in the U.S will help health care providers (nurses, doctors, physician assistants) improve the health visit by considering what is important to you. Your ideas are needed and valuable. Physicians, nurses and others will have a better understanding of what is important to patients as a result of your ideas and experiences.

If you decide to participate, you will meet with the researcher (Debra) at least two times. You can meet her wherever you decide. She will ask you questions about your journey to the U.S. and about your opinion and experiences in regards to your health visits while living in the U.S. You are welcome to share anything you desire. She will ask if you are willing to have your voice recorded as you talk about your experiences. Your name will never be connected with anything you say and you will never be mentioned. All that you share will be confidential.

How will this information be used? During the study the recordings will be kept private. Your name will not be attached to your voice. The information you share will be put into written English by a translator. Then the writing will be analyzed for common ideas that are found among other participants. After the study is done, all recordings and papers will be destroyed.

What you share is kept confidential. Your ideas are important in helping others understand your health needs and preferences. Thank you for considering participation in this study.

If you would like to participate, you can call Debra at 801-582-2262. She speaks Arabic. Or, you can give your phone number to those providing this information and Debra will call you.

APPENDIX B

RECRUITMENT LETTER TO HEALTH PROVIDERS

The Health Encounter Counts: Research to Make a Positive Difference

Date:

Dear Health Provider,

You have been noted as one of the few providers in the community that cares for a diverse population of patients. For this reason, it would be a privilege to have the opportunity to learn from your experiences.

I am conducting a qualitative study and would like to consider your experiences and perceptions of the health care encounter. Your perspective is of great value to this study and no doubt will add important knowledge to the components that facilitate good patient care and communication between health care provider and patients of diversity.

As a primary health provider, I am very interested in gaining from your experience and would be delighted if you consider participating. The study involves a very short demographic survey and a 20-30 minute interview about your clinical experiences and perceptions. My research is conducted through the University of Utah and has IRB approval.

I will be following up with a call to discuss this research and to ask if you would be willing to participate. If you would prefer to contact me first, please feel free to do so.

Thank you for your consideration.

Sincerely,

Deb Penney CNM MS MPH
10 South 2000 East
Salt Lake City, UT 84112
801-581-7924
Email: debra.penney@nurs.utah.edu

APPENDIX C

COVER LETTER FOR IRAQI PARTICIPANTS

رسالة موافقة

لقاء المريض ومقدم الرعاية الصحية والتصورات و التجارب

إن الغرض من هذه الدراسة البحثية هو وصف الخبرات والتصورات لتفاعل المريض مع من يقدم له الخدمة الصحية أثناء أي زيارة صحية .
نقوم بهذه الدراسة لأن الاختلافات بين المريض ومقدم الخدمة الصحية قد يؤثر على زيارات الرعاية الصحية.

أود منك استكمال استبيان قصير ومن ثم المشاركة في مقابلة حول الزيارات الصحية .إن مشاركتكم ستساعد على زيادة التفاهم حول هذه
الزيارة الصحية .المخاطر في المشاركة ضئيلة جدا ويمكن أن تشمل تذكر وسرد مواقف صعبة وهو ما قد يبدو مزعجاً. يمكنك التوقف في أي
وقت. سوف يتم دفع تعويض مالي قدره \$25 على شكل بطاقة هدية (gift certificate) في نهاية المقابلة.

المعلومات التي سيتم جمعها ستكون سرية تماما .لن يطلب منك التوقيع على أي أوراق ولن يتم ربط أي معلومات تقدمها مع هويتك. قبل أن
تبدأ، سوف يتم سؤالك عما إذا كنت تفهم هذه الدراسة وراغب بالمشاركة. قبل أن يُسجل صوتك، فإن الباحث سيسأل عن الاسم الأول ورقم
الهاتف إذا احتجنا الاتصال بك في المستقبل لتوضيح ما قلته في المقابلة. كما يطلب منك ملء استمارة قصيرة مع الأسئلة. سوف إعلامك متى
يبدأ التسجيل وعندما يتوقف. يمكنك أيضا أن تطلب إيقاف التسجيل أو المقابلة في أي وقت. الغرض من التسجيل هو معرفة تصوراتك
والتجارب الخاصة بك أثناء الزيارات الصحية من خلال كلماتك.

لحماية هويتك، سيتم إعطاء رقم معين للمقابلة المسجلة بدلا من اسمك. قبل ان تبدأ المقابلة، سوف يُطلب منك اسمك ورقم الهاتف، وهذه
المعلومات المكتوبة هي الوحيدة المتاحة للباحث، وسيتم الاحتفاظ بها في ملف محمي بكلمة مرور على جهاز كمبيوتر في مكتب مقفل. سوف
يتم سماع مقابلتك ونسخها بواسطة الباحث. إذا كنت تتكلم العربية، فإن ما لا يتجاوز شخصين من المترجمين سيعملون معا للاستماع إلى
التسجيل قبل تدوينه حتى يتمكنوا من جعل الترجمة أكثر دقة. وسيتم تخزين المسجل في درج مقفل في مكتب البحوث المقفل عندما لا يتم
استخدامها. وسيتم تحويل جميع التسجيلات الصوتية إلى وثائق.

سوف يتم تحليل الوثائق لجمع معناها وأفكارها سيتم جمعها سوية. وستبقى هذه الوثائق والاستبيان القصير الذي ستملؤه في ملف كمبيوتر
محمي بكلمة مرور وسيكون متاحاً فقط لأولئك الذين يشاركون مباشرة في البحث (وهذا يشمل اثنين من المترجمين والباحث ولجنة البحوث
في الجامعة التي تتكون من 5 أساتذة). جميع الأوراق سيتم تمزيقها بعد أن تُدخل على شكل وثيقة كمبيوترية محمية. الكلمات التي تسردها لن
تكون مرتبطة مع اسمك ولكن قد تتم مراجعتها من قبل المعنيين مباشرة في البحث وقد تظهر على شكل اقتباسات في منشورات مستقبلية. في
نهاية الدراسة (تصل إلى 24 شهرا) سيتم حذف والتخلص من كل ملفات الكمبيوتر والتسجيلات الصوتية.

إذا كان لديك أي أسئلة أو شكاوى أو إذا كنت تشعر بأنك تضررت بسبب هذا البحث، الرجاء الاتصال بالسيدة ديبرا بيني، (Penney Debra)
في كلية التمريض، جامعة ولاية يوتا على الرقم التالي: 801-581-7924.

إذا كان لديك أسئلة حول حقوقك كمشارك في البحث، اتصل بمجلس المراجعة المؤسسي (IRB) وكذلك، إذا كان لديك أسئلة أو شكاوى أو
مخاوف لا تشعر بأنك يمكن أن تناقشها مع من يقوم بالبحث. ويمكن الوصول إلى IRB العائد لجامعة ولاية يوتا عن طريق الهاتف -581(801)
3655 أو عن طريق البريد الإلكتروني irb@hsc.utah.edu

يمكن أن يستغرق استكمال الاستبيان والمقابلة القصيرة حوالي 30 دقيقة إلى ساعة واحدة. المشاركة في هذه الدراسة هو طوعي. يمكنك اختيار
عدم المشاركة. يمكنك اختيار عدم الانتهاء من الاستبيان أو المقابلة أو حذف أي سؤال تفضل عدم الرد عليه دون عقوبة أو خسارة للمنافع.

إن ملء هذا الاستبيان القصير يعني انك تعطي موافقتك على المشاركة.

أشكرك على مشاركتك.

APPENDIX D

CONSENT COVER LETTER FOR HEALTH PROVIDER PARTICIPANTS

Consent Cover Letter

Patient and Provider Health Care Encounter Experiences and Perceptions

You are being asked to take part in a research study. Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Ask us if there is anything that is not clear or if you would like more information. Your participation is voluntary. The study involves filling out a brief questionnaire and participating in a recorded interview. The purpose of this research study is to describe experiences and perceptions of the patient and health provider interaction at a health visit. We are doing this study because differences between patient and health provider may influence health care visits.

It will take about 30 minutes to one hour to complete this study. Before starting, you will be asked if you understand the study and are willing to participate. Before recording your voice, the researcher will ask for your first name and phone number in case we need to contact you in the future to clarify what you said in the interview. You will also be asked to fill out a short form with questions. You will be told when the recording starts and stops. You can also ask that the recording or interview be stopped at any time. The purpose of the recording is to capture your perceptions and experiences of health visits through your words.

The risks in this study are minimal. You may feel upset thinking about or talking about personal information related to your past experiences. If you feel upset from this experience, please tell the researcher, and she will tell you about resources available to help.

There are no direct benefits for taking part in this study. However, we hope the information from this study may help develop a greater understanding of how patients and health providers can improve future health visits. You will be compensated with a \$25 gift certificate at the end of the interview.

Any information you provide will be kept strictly confidential. We will keep all research records that identify you private to the extent allowed by law. To protect your identity, a number will be assigned to your recorded interview instead of your name. The interview will take place in a private location of your choice. Before the interview you will be asked about demographic information. The interviews will be recorded. Your recorded interview will be heard by the researcher and transcribed into documents. The recorder will be stored in a locked drawer in the locked research office when not being used. The documents will be analyzed for their meaning and ideas will be grouped together. These documents and the short survey you filled out will be kept in a password protected computer file that is available only to those directly involved in the research (this includes the researcher and the University research committee consisting of 5 professors). All papers will be shredded after the information from them is entered into the secure computer protected form. The words you share will never be connected with your name but they may be reviewed by those involved directly in the research and may appear as quotes in future publications. At the end of the study (up to 24 months), all computer

files and audio recordings will be permanently deleted and destroyed.

In some cases reporting of confidential information may not be required by law but other institutional or professional ethics codes will require reporting to the appropriate authorities. If you disclose instances that are serious threats to individuals, or to public safety, these must be reported.

If you have questions, complaints or concerns about this study, or if you feel you have been harmed as a result of participation please call Debra Penney at 801-581-7924 at any time.

Contact the Institutional Review Board (IRB) if you have questions regarding your rights as a research participant. Also, contact the IRB if you have questions, complaints or concerns which you do not feel you can discuss with the investigator. The University of Utah IRB may be reached by phone at (801) 581-3655 or by e-mail at irb@hsc.utah.edu.

You may also contact the Research Participant Advocate (RPA) by phone at (801) 581-3803 or by email at participant.advocate@hsc.utah.edu.

You will not need to sign this document, but you will be asked for your consent to participate verbally.

By verbally consenting to this study, you confirm that you have read the consent, or have had it verbally explained and that you have had the opportunity to ask questions. You will be given a copy of this information for your reference.

Thank you for your participation.

APPENDIX E

IRAQI PARTICIPANT INTERVIEW QUESTIONS

Access:

- Do you have any difficulties getting to your health appointment? Like transportation? Waiting to make an appointment?

Doctor Type

1. How did you choose your doctor?
2. Would you be open to having a male doctor for a female problem? Can you explain?
3. What makes your primary doctor good or not so good?

Doctor competence

4. In your health visit, do you feel you received the correct care for your problem?

Health visit

5. Do other women talk about their health visits? What have you heard?
6. Can you explain what happens in your health visit? (From beginning to end)
7. What was your worst visit? (can you tell me about it?)
8. What was your best visit? (What made it good?)

Communication

9. How was the communication in your health visit? For example:
 - Did you use a translator?
 - If yes: What kind? (phone, person, gender difference?)
10. In your opinion, what makes for a good translator?
11. How well did you understand the provider? Did you ever feel lost in the conversation?

Time/Understanding

12. Tell me about the provider, did he/she seem to be in a hurry or was there enough time for you to talk with him/her?
13. What parts of your care did the doctor explain to you?
14. Did you feel respected or not? Can you explain what happened?

Provider knowledge of Islam

15. In order to give the best medical care and advice, should your doctor have some knowledge about you? For example your story, culture, religion, traditions? What would be important things to know?

16. Do you think your doctor knows about these important things?

Other's perceptions of Muslim.

17. Has an American woman asked you why you wear the hijab, what did you say?

18. If no, if a woman asked about why you wear the hijab, what would you say?

19. Are you facing any difficulties in public by being a Muslim? Have people made comments or treated you with disrespect? Can you explain?

If yes- Does anything like that happen at health visits?

20. Do you have any fears?

APPENDIX F

HEALTH PROVIDER PARTICIPANT

INTERVIEW QUESTIONS

PROVIDER QUESTIONS

Research has shown there are disparities in health care among those who differ from their provider racially, ethnically, culturally, linguistically or by gender. Overall, how does your practice fall in line with this trend or seek to improve on meeting the needs of those with differing backgrounds?

What level of care do you think these women receive compared to someone born in the US?

Barriers/frustrations:

Personal:

In your experience, what barriers do you face in giving care?

What aspects of your gender act as a barrier or a help in the patient/provider relationship?

System Barriers

What limitations are there in your current system for women like these? Time? Translator?

What are other frustrations with giving care?

Adjustments:

How have you adjusted to giving care to them?

If you were to train a resident, what attitude would be helpful to instill in them when dealing with this population, in particular, women?

Perception:

When a patient comes into your office how do you identify a patient as Iraqi ? Muslim? Or refugee?

How would you identify these women in public or could you?

Does the EMR ask for religious preference of the patient?

In your experience, when treating patients, how important is their religion?

Have you run across any religious practice as harmful or beneficial?

What is the most helpful skill a refugee woman of Muslim background can have in getting the most out of the health care visit with you?

Overall, how do these patients view you? Respect? Too much respect?

What sense do you have of their expectations of you? Any ideas?

In your estimation, how much has the media after 9/11 influenced what you know about Muslims?

In your opinion, and from your experience in giving care to them, are they oppressed? Can you explain?

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